STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525623	A. Building B. Wing	02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nu Roc Health and Rehabilitation Ctr	3576a Nu Roc LN Laona, WI 54541

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, staff interview, record review, and policy review, the facility did not ensure direct care staff were aware of enhanced barrier precautions (EBP) for 3 residents (R) (R10, R11, and R12) of 10 sampled residents. R10 was on EBP but did not have an order or the appropriate signage to indicate the necessary precautions. R11 and R12 were on EBP but did not have the appropriate signage to indicate the necessary precautions.Findings include:Review of the facility's Enhanced Barrier Precautions policy, with an implementation date of 2/5/25 and a revision date of 9/9/25, indicates: It is the guideline of this facility to implement enhanced barrier precautions (EBP) for the prevention of transmission of multidrug-resistant organisms (MDROs). The definition for 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. The section titled Explanation and Compliance Guidelines indicates: 1. Prompt recognition of need. c. The facility will have the 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 activities. 2. Initiation of EBP: b. An order for EBP will be obtained for residents with any of the following: i. Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes .) 1. Review of R10's undated admission Record revealed an original admission date of 1/28/24 and a recent admission date of 1/28/26. R10 had diagnoses including chronic kidney disease, obstructive and reflux uropathy, unspecified, benign prostatic hyperplasia with lower urinary tract symptoms, and chronic kidney disease.Review of R10's Clinical Physician Orders revealed there was not a physician's order for EBP or Special Instructions noted on the Clinical Physician Orders for EBP.Review of R10's Quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 1/24/26, revealed R10 had an indwelling catheter. During an observation on 2/9/26 at 3:30 PM, R10 was sitting in a wheelchair. R10's indwelling urinary catheter tubing was observed at the base of R10's pant leg. There was no signage in R10's room that indicated R10 was on EBP due to the indwelling catheter.During an interview on 2/9/26 at 4:15 PM after Registered Nurse (RN)1 entered R10's room to connect portable oxygen for R10, RN1 was asked if R10 was on EBP. RN1 stated he was not aware. Surveyor notified RN1 that R10 was on oxygen and had a urinary catheter. When asked if RN1 should have applied PPE, RN1 stated he did not know. 2. Review of R11's undated admission Record revealed an original admission date of 10/9/25 and a recent admission date of 2/5/26. R11 had a diagnosis of neuromuscular dysfunction of the bladder, unspecified.Review of R11's Quarterly MDS assessment, with an ARD of 2/2/26, revealed R10 had an indwelling catheter.Review of R11's Clinical Physician Orders revealed Special Instructions which indicated: History methicillin-resistant Staphylococcus Aureus (MRSA) ENHANCED BARRIER PRECAUTIONS.During an observation and interview on 2/9/26 at 3:30 PM, R11 was observed in bed. R11 stated he was waiting on the nurse to check on him and stated his catheter was giving him some trouble. (continued on next page)

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

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At the time of the observation, there was no signage to indicate R11 was on EBP.3. Review of R12's undated admission Record revealed an admission date of 1/21/26 and diagnoses including retention of urine, unspecified with an onset date of 12/17/25.Review of R12's 5-day MDS assessment, with an ARD of 1/26/26, revealed R12 had an indwelling catheter.Review of R12's Clinical Physician Orders revealed Special Instructions which indicated: ENHANCED BARRIER PRECAUTIONS.During an observation on 2/9/26 at 3:51 PM, R12 was in bed. A catheter bag was observed on the side of the bed closest to the doorway. No signage was observed to indicate R12 was on EBP.During an interview on 2/10/26 at 10:38 AM, when asked if Certified Nursing Assistant (CNA)3 knew if any assigned residents were on EBP, CNA3 stated it was on the assignment sheet. Surveyor observed the CNA assignment sheet posted on the back of the nurses' station entry door. The assignment sheet provided the names of staff working and their assigned area. The assignment sheet did not indicate which residents were on EBP.During an interview on 2/10/26 at 10:40 AM, when asked how CNA4 knew if any assigned residents were on EBP, CNA4 stated it was pretty much vocal. When asked if CNA4 was notified when she received her assignment, CNA4 stated she was not notified of any residents on EBP.During an interview on 2/10/26 at 10:42 AM, Licensed Practical Nurse (LPN)1 was notified that Surveyor was told residents on EBP were listed on assignment sheets. LPN1 stated the information was on the Kardex (an abbreviated care plan used by nursing staff) which was on the back of residents' doors in a yellow binder. On 2/10/26 beginning at 10:45 AM, Surveyor observed the contents of the yellow binders on the back of R10, R11 and R12's doors. The binders contained each resident's Kardex which contained care instructions. The Kardexes did not mention EBP for R10, R11, and R12 even though R10, R11, and R11 had indwelling catheters. During an interview on 2/10/26 at 10:57 AM, Surveyor notified the Director of Nursing (DON) that all residents who should be on EBP did not have signage or posting. The DON stated there was a resident in the facility who would remove the signage and the information should be posted at the nurses' station with staff assignments. When Surveyor informed the DON that staff were unaware of residents on EBP and where the information was located, the DON stated she was aware of what CNA4 and LPN1 told Surveyor about residents on EBP and the location of the information.