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	06/18/2025

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

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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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure a Pre-admission Screening and Resident Review (PASRR) Level II Screen was completed for 1 resident (R) (R3) of 14 sampled residents. R3's PASRR Level I Screen was inaccurate and indicated R3 did not have a diagnosis of a mental health disorder and was not prescribed medication to treat a mental health disorder. As a result, a PASRR Level II Screen was not submitted to determine if R3 was in need of specialized services. Findings include: The facility's Resident Assessment-Coordination with PASARR Program policy, dated 9/18/24, indicates: This facility coordinates assessments with the preadmission screening and resident review (PASARR) program under Medicaid to ensure individuals with a mental disorder (MD), intellectual disability (ID), or a related condition receive care and services in the most integrated setting appropriate to their needs .1. All applicants to this facility will be screened for serious mental disorders or intellectual disabilities and related conditions in accordance with the state's Medicaid rules for screening. A. PASARR Level I-initial pre-screening is completed prior to admission. I. Negative Level I screen-permits admission to proceed and ends the PASARR process unless a possible serious mental disorder or intellectual disability arises later. ii. Positive Level I screen-necessitates a PASARR Level II evaluation prior to admission. B. PASARR Level II-a comprehensive evaluation by the appropriate state-designated authority (cannot be completed by the facility) that determines whether the individual has a mental disorder, intellectual disability, or related condition, determines the appropriate setting for the individual, and recommends any specialized services and/or rehabilitative services the individual needs. 2. The facility will only admit individuals with a mental disorder or intellectual disability who the state mental health or intellectual disability authority has determined as appropriate for admission .6. The Social Services Director shall be responsible for keeping track of each resident's PASSAR screening status, and referring to the appropriate authority . On 6/16/25, Surveyor reviewed R3's medical record. R3 was admitted to the facility on [DATE] and had diagnoses including anorexia and major depressive disorder. R3 was prescribed mirtazapine (an antidepressant medication used primarily to treat major depressive disorder). R3's Minimum Data Set (MDS) assessment, dated 4/5/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R3 had intact cognition. (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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's medical record indicated R3 was screened for mental illness, developmental disabilities, and intellectual disabilities with a PASRR Level I Screen completed after R3 was admitted to the facility. The Level I Screen indicated R3 did not have a major mental health disorder and had not received psychotropic medication to treat symptoms or behaviors of a major mental health disorder. The PASRR Level I Screen also indicated R3 was not suspected of having a serious mental illness and did not indicate R3 was prescribed antidepressant medication and had a diagnosis of major depressive disorder. A PASRR Level II Screen was not completed for R3. On 6/17/25 at 8:30 AM, Surveyor interviewed Social Worker (SW)-F who indicated R3 was prescribed mirtazapine and had a diagnosis of major depressive disorder upon admission. SW-F indicated normally SW-F would have included that on the PASRR Level I Screen. On 6/18/25 at 8:57 AM, SW-F approached Surveyor and indicated SW-F did an audit to ensure all PASRR Screens were in compliance. SW-F indicated SW-F would resubmit R3's PASRR Level I Screen with accurate information.

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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 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** 2. On 6/16/25, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] and had diagnoses including chronic obstructive pulmonary disease (COPD) and heart failure. R2's MDS assessment, dated 5/27/25, had a BIMS score of 15 out of 15 which indicated R2 had intact cognition. R2 had a physician order, dated 5/27/25, for oxygen 4 liters per nasal cannula continuous every shift for hypoxia. On 6/16/25 at 11:09 AM, Surveyor noted R2's oxygen concentrator was running at 4 liters per minute and R2's nasal cannula was on R2's bed, however, R2 was not in the room. On 6/16/25 at 11:14 AM, Surveyor observed R2 return from having R2's hair washed and noted R2 was not using portable oxygen. Surveyor interviewed R2 who indicated R2 did not wear oxygen when R2's hair was washed or when R2 ate. Surveyor interviewed CNA-J who confirmed R2's oxygen concentrator should have been turned off when R2 left the room. On 6/17/25 at 9:42 AM, Surveyor interviewed DON -B who verified R2's oxygen concentrator should have been turned off when R2 was not in the room. Based on observation, staff and resident interview, and record review, the facility did not ensure the resident environment was as free of accident hazards as possible for 2 residents (R) (R5 and R2) of 4 sampled residents. On 6/16/25, Maintenance Director (MD)-G encouraged R5 to transfer independently from wheelchair to bed. R5's care plan indicated R5 required the assistance of one staff for transfers. On 6/16/25, R2's oxygen concentrator was running at a flow rate of 4 liters per minute in R2's room when not in use and when R2 was out of the room. Findings include: The facility's Competency Evaluation policy, dated 8/21/24, indicates: .It is the guideline of this facility to evaluate each employee to assure they meet appropriate competencies and skills for performing their job .1. The knowledge and skills required among staff to meet residents' needs are determined through the facility assessment process . The facility's Safe Resident Handling/Mobility/Transfers policy, revised 11/29/23, indicates: .14. Resident lifting and transferring will be performed according to the resident's individual plan of care . The facility's Oxygen Concentrator policy, revised 3/12/25, indicates: An oxygen concentrator is a medical device that extracts oxygen from room air by filtering out or separating the nitrogen from oxygen. The oxygen passes through a filter system and is stored within the device for delivery based on flow meter setting .4. Use of concentrator .k. Keep turned off when set up for use in resident's room but not actively in use. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The American Lung Association (https://www.lung.org 12/15/23) Using Oxygen Safely states: Oxygen . supports combustion. Materials burn more readily in an oxygen-enriched environment .Store Oxygen Safely: Turn off your oxygen when you're not using it. Don't set the cannula or mask on the bed or a chair if the oxygen is turned on. 1. On 6/16/25, Surveyor reviewed R5's medical record. R5 was admitted to the facility on [DATE] and had diagnoses including dementia, fibromyalgia, osteoarthritis, spondylopathy, abnormal gait and mobility, anxiety, and low back pain. R5's Minimum Data Set (MDS) assessment, dated 3/12/25, had a Brief Interview for Mental Status (BIMS) score of 8 of 15 which indicated R5 had moderate cognitive impairment. The MDS assessment also indicated R5 had two falls since last the MDS assessment. R5's care plan, dated 7/6/23, indicated R5 transferred with 1 assist. On 6/16/25 at 2:01 PM, Surveyor observed MD-G encourage R5 to self-transfer from wheelchair to bed so MD-G could repair R5's wheelchair. Surveyor observed R5 transfer from the wheelchair to R5's bed without assistance except verbal cueing from MD-G. On 6/17/25 at 1:10 PM, Surveyor interviewed MD-G who indicated MD-G had seen R5 transfer independently and felt it was okay to encourage R5 to transfer from wheelchair to bed without assistance. MD-G stated if MD-G was unsure of resident's transfer status, MD-G could check the care plan on the back of the resident's door or ask a Certified Nursing Assistant (CNA) for help. MD-G verified MD-G did not check the care plan on the back of R5's door prior to encouraging R5 to transfer independently. On 6/17/25 at 1:16 PM, Surveyor interviewed CNA-H who indicated R5 should transfer with the assistance of one staff and verbal cueing, however, R5 often self-transferred. On 6/17/25 at 2:43 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated MD-G should not transfer residents and should not have encouraged R5 to self-transfer from wheelchair to bed.

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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 ensure 2 residents (R) (R6 and R37) of 6 sampled residents were provided safe administration of drugs and biologicals. R6 had an order for 81 milligrams (mg) of enteric coated (EC) aspirin daily. On 6/17/25, R6 was administered 81 (mg) of chewable aspirin. R37 had an order for a 4% lidocaine patch on the back at bedtime and removed in the morning. On 6/17/25, staff put a 4% lidocaine patch on R37's left knee. Findings include: The facility's Medication Administration policy, revised 11/12/24, indicates: .10. Ensure the six rights of medication administration are followed: a. right resident; b. right drug; c. right dosage; d. right route; e. right time; f. right documentation . 1. On 6/17/25, Surveyor reviewed R6's medical record. R6 was admitted to the facility on [DATE] and had diagnoses including diabetes, chronic obstructive pulmonary disease (COPD), and epilepsy. R6's Minimum Data Set (MDS) assessment, dated 3/22/25, included a Brief Interview for Mental Status (BIMS) score of 8 out of 15 which indicated R6 had moderately impaired cognition. On 6/17/25 at 7:00 AM, Surveyor observed Licensed Practical Nurse (LPN)-I prepare medication to administer to R6 and noted one of the medications was an 81 mg chewable aspirin tablet. On 6/17/25 at 7:36 AM, Surveyor observed LPN-I administer R6's AM medications in the dining room, including an 81 mg chewable aspirin tablet. On 6/17/25 at approximately 10:00 AM, Surveyor reviewed R6's medication orders and noted R6 had an order for aspirin oral capsule 81 mg give 1 tablet by mouth one time a day for deep vein thrombosis (DVT) prophylaxis, dated 11/28/23. On 6/17/25 at 10:33 AM, Surveyor interviewed LPN-I who reviewed the order and indicated the order was transcribed incorrectly because the facility did not carry aspirin in capsule form. Upon review of R6's admission orders, it was noted the order was for aspirin enteric coated (EC) once per day. On 6/17/25 at 10:54 AM, Surveyor interviewed Director of Nursing (DON)-B who confirmed R6's order should have been for aspirin 81 mg EC and indicated a chewable 81 mg tablet should not have been administered in place of EC aspirin. 2. On 6/17/25, Surveyor reviewed R37's medical record. R37 was admitted to the facility on [DATE] and had diagnoses including acute gastrojejunal ulcer with perforation, pain, and a gastrostomy. R37's MDS assessment, dated 4/24/25, included a BIMS score of 15 out of 15 which indicated R37 had intact cognition. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/17/25 at 7:50 AM, Surveyor observed LPN-I apply a 4% lidocaine patch to R37's left knee during the AM medication pass. On 6/17/25 at approximately 10:30 AM, Surveyor reviewed R37's medication orders and noted R37 had an order for a 4% lidocaine patch, dated 5/5/25, that indicated the patch should be placed on R37's back at bedtime (HS) and taken off in the morning (AM). On 6/17/25 at 10:59 AM, Surveyor interviewed DON-B who indicated LPN-I should not have put the lidocaine patch on R37's left knee and verified the patch should have been placed on R37's back at bedtime and removed in the morning.

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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 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 prepared in a safe and sanitary manner. This practice had the potential to affect all 34 residents residing in the facility. Staff did not monitor and document food cooling temperatures. Staff did not test the Quaternary sanitizing solution (used to sanitize food preparation surfaces) per manufacturer's instructions and did not have a procedure to monitor and document the temperature and parts per million (PPM) of the sanitizing solution. Staff did not monitor warewashing temperatures to ensure the minimum wash and rinse temperatures were achieved to prevent the spread of foodborne illness. In addition, the PPM of the facility's low temperature warewashing machine were not monitored and documented per manufacturer's recommendations. Staff did not date items upon receipt or opening. Findings include: Cooling Foods: The 2022 Federal Food and Drug Administration (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° Celsius (C) (135 °Fahrenheit (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 § 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. During a self-guided kitchen tour that began at 9:40 AM on 6/16/25, Surveyor observed one container labeled egg salad dated 6/14 and one container labeled pasta salad dated 6/15 in the walk-in cooler. Surveyor noted there was not a food cooling log in the kitchen. On 6/17/25 at 2:40 PM, Surveyor toured the kitchen with Dietary Manager (DM)-D who indicated the facility did not have a procedure for keeping and cooling cooked foods for resident consumption at a later date. DM-D indicated the pasta and egg salads were discarded after Surveyor's observation on 6/16/25. DM-D indicated the salads should not have been saved because it was not part of the facility's process to keep and cool leftover food. DM-D indicated DM-D had to throw away food all the time because staff continuously saved food that was cooked and not cooled properly. Quaternary Sanitizer: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Hydrion Quaternary test strip package insert indicates the test solution should be between 65 and 75 degrees Fahrenheit (F) at the time of testing. During an initial kitchen tour that began at 9:40 AM on 6/16/25, Surveyor observed staff use buckets of sanitizing solution to clean food preparation surfaces. Surveyor did not observe a log for testing the sanitizing solution. On 6/17/25 at 2:40 PM, Surveyor interviewed DM-D who indicated DM-D spoke with a supervisor regarding the procedure to test the Quaternary sanitizing solution and a log to document the appropriate PPM of the solution. DM-D confirmed dietary staff did not test the sanitizing solution and did not have a log to record the PPM. Dietary Aide (DA)-K indicated DA-K prepared the sanitizing buckets throughout the day and confirmed dietary staff do not test the PPM of the sanitizing solution. Warewashing: The facility's Warewashing policy, revised 9/2017, indicates: .All dishware, serviceware, and utensils will be cleaned and sanitized after each use .2. All dish machine water temperatures will be maintained in accordance with manufacturer's recommendations for high temperature or low temperature machines. 3. Temperature and/or sanitizer concentration logs will be completed, as appropriate . The 2022 FDA Food Code documents at section 4-501.17: When used for warewashing, the wash compartment of a sink, mechanical warewasher, or wash receptacle of alternative manual warewashing equipment as specified in 4-301.12 (C), shall contain a wash solution of soap, detergent, acid cleaner, alkaline cleaner, degreaser, abrasive cleaner, or other cleaning agent according to the cleaning agent manufacturer's label instructions During a continuous kitchen observation on 6/17/25 at 9:01 AM, Surveyor observed the warewashing machine which displayed the manufacturer's recommendation of 120-140 degrees F for the wash cycle and 120-140 F for the rinse cycle as well as 50-100 PPM for the chemical PPM. Surveyor observed then observed [NAME] (CK)-L wash dishes in the warewashing machine. Surveyor observed the following readings during two separate cycles of dishes washed in the warewashing machine: ~ 110 degrees F for the wash cycle and 110 degrees F for the rinse cycle ~ 110 degrees F for the wash cycle and 110 degrees F for the rinse cycle Following the observation, Surveyor interviewed CK-L who indicated the warewashing machine can take a while to heat up and dishes should be rerun if the machine does not reach the minimum temperatures. Surveyor noted CK-L left the two cycles of dishes on the counter to dry and did not observe CK-L or other dietary staff rerun the dishes through a cycle that reached the recommended temperatures. DM-D indicated the warewasher was not reaching the required temperatures and Maintenance Director (MD)-G was informed earlier that morning. DM-D indicated MD-G informed DM-D the low temperatures of the wash and rinse cycles were normal and to run the dishes through several times to reach the required temperatures. DM-D confirmed MD-G did not indicate that a request for service was submitted. On 6/17/25 at 9:09 AM, Surveyor observed the warewashing machine with MD-G which was run for two cycles. Surveyor and MD-G observed the following temperatures: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	~ 112 degrees F for the wash cycle and 112 degrees F for the rinse cycle ~ 111 degrees F for the wash cycle and 112 degrees F for the rinse cycle Following the observation, MD-G confirmed the warewashing machine was run for several cycles that morning and did not reach the appropriate temperatures. MD-G indicated MD-G would call the vendor to service the machine. On 6/17/25 at 10:57 AM, MD-G approached Surveyor and asked what temperatures the warewashing machine was supposed to reach. MG-D indicated MD-G wanted to know what temperatures Surveyor wanted the machine to reach because the machine could be set to whatever temperature the facility wanted for wash and rinse cycles. Surveyor indicated the manufacturer's temperature recommendations on the front of the machine were what the warewashing machine needed to reach. MD-G indicated the vendor was coming on 6/17/25 to service the machine. On 6/17/25 at 1:43 PM, MD-G approached Surveyor and indicated the thermometer on the warewashing machine was not working correctly and a new thermometer was ordered. MD-G also indicated the booster for the warewasher was set to 130 degrees F. On 6/17/25, Surveyor reviewed the facility's May and June 2025 Dish Machine Logs which documented wash and rinse cycle temperatures and the PPM per cycle for breakfast, lunch, and dinner and noted the following: ~ Chemical Sanitizing (low temp) Wash 120 degrees F-140 degrees F; Rinse 120 degrees F-140 degrees F Manufacturer recommended PPM 50-100. Surveyor noted 27 of 93 PPM entries on the May 2025 Dish Machine Log were out of range with 120 PPM documented as the lowest and 200 PPM as the highest. Five wash cycles were out of the required range with the lowest wash cycle documented at 104 degrees F. Six rinse cycles were out of the required range with the lowest rinse cycle documented at 118 degrees F. Surveyor reviewed the June of 2025 Dish Machine Log for 6/1/25 through the 6/17/25 lunch meal and noted 27 of 51 PPM entries were out of range with 20 PPM documented as the lowest and 200 PPM as the highest. Ten wash cycles were out of the required range with the lowest wash cycle documented at 102 degrees F. Eleven rinse cycles were out of the required range with the lowest rinse cycle documented at 112 degrees F. On 6/17/25 at 2:40 PM, Surveyor interviewed DM-D who verified the warewasher documentation logs did not contain correct monitoring and documentation of wash and rinse cycles and PPM. During the interview, DA-K indicated the warewasher sanitizer was set to a level 5 and but should be at 2.5 which further indicated documentation and monitoring of the warewasher was not followed per the facility's policy or the FDA Food Code. Undated, Expired, and Undated Food: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's Food Storage: Cold Foods policy, revised 9/2017, indicates: All time/temperature control for safety foods, frozen and refrigerated, will be appropriately stored in accordance with guidelines of the FDA Food Code .5. All foods will be stored, wrapped, or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination . The facility's Food Storage: Dry Goods policy, revised 9/2017, indicates: All dry goods will be appropriately stored in accordance with guidelines of the FDA Food Code . The 2022 FDA Food Code documents at 3-501.18 Ready-to-Eat, Time/Temperature Control for Safety Food, 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) 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). During a self-guided kitchen tour that began at 9:40 AM on 6/16/25, Surveyor observed the following: Walk-In Cooler: ~ An open and undated container of Cool Whip ~ A undated bag of cheese slices ~ Four and a half undated loaves of bread ~ Two undated bags of hot dog buns ~ One undated bag of hamburger buns Stand-Up Freezer: ~ An undated bag of 15 pancakes ~ Three undated containers of Cool Whip ~ One undated sleeve of French toast ~ One undated and freezer-burned bag of BBQ pork ribs ~ One undated bag of chicken patties ~ One bag of sauerkraut dated 2/17/25 ~ One undated bag of French fries (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	~ One bag of meatballs dated 3/16 ~ One bag of turkey and gravy dated 2/16 ~ One bag of crab cakes dated 1/17 During the kitchen tour, DM-D entered the kitchen and observed the following items with Surveyor in the dry storage area and outside freezer: Dry Storage Area: ~ One dented can of pumpkin ~ Five undated jars of salt ~ One undated container of Hawaiian Punch Outside Freezer: ~ One undated bag of chopped onions Following the observation, DM-D verified the bag of chopped onions was undated and indicated the onions would be thrown away. During a continuous kitchen observation that began at 9:09 AM on 6/17/25, Surveyor observed the following: Walk-In Cooler: ~ An open and undated container of Cool Whip ~ A undated bag of cheese slices ~ Four and a half undated loaves of bread ~ Two undated bags of hot dog buns ~ One undated bag of hamburger buns Stand-Up Freezer: ~ An undated bag of 15 pancakes ~ Three undated containers of Cool Whip ~ One undated sleeve of French toast ~ One undated and freezer-burned bag of BBQ pork ribs (continued on next page)

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	06/18/2025

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

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	~ One undated bag of chicken patties ~ One bag of sauerkraut dated 2/17/25 ~ One undated bag of French fries ~ One bag of meatballs dated 3/16 ~ One bag of turkey and gravy dated 2/16 ~ One bag of crab cakes dated 1/17 ~ One undated bag of chopped onions previously observed in the outside freezer on 6/16/25 Dry Storage Area: ~ Five undated jars of salt ~ One undated container of Hawaiian Punch On 6/17/25 at 2:40 PM, Surveyor interviewed DM-D who confirmed the above items were open, undated, and/or expired. DM-D indicated food removed from boxes should be labeled with the date received so open dates, use-by dates, and expiration dates can be monitored. DM-D also indicated food should be labeled with open and use-by dates. DM-D confirmed the facility's policy is for frozen food to be thrown away after 3 months and verified the sauerkraut, meatballs, crab cakes, and turkey and gravy were expired and should not be in the freezer for resident consumption.

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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 0851 Level of Harm - Potential for minimal harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on staff interview and record review, the facility did not ensure accurate mandatory staffing information based on payroll data was submitted to the Centers for Medicare & Medicaid Services (CMS). This practice had the potential to affect all 34 residents residing in the facility. Staffing information for fiscal quarter 2 (1/25/25-3/31/25) of the Payroll Based Journal (PBJ) was not submitted accurately to CMS. Findings include: The Centers for Medicare & Medicaid Services (CMS) Electronic Staffing Data Submission Payroll-Based Journal, Long-term Care Facility Policy Manual, dated 6/2022, indicates: .Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS .Submission Timelines and Accuracy: Direct care staffing and census data will be collected quarterly and is required to be timely and accurate .Report Quarter: Staffing and census data will be collected for each fiscal quarter. Staffing data includes the number of hours paid to work by each staff member each day within a quarter. Census data includes the facility's census on the last day of each of the three months in a quarter. The fiscal quarters are as follows: Fiscal Quarter, Date range: (quarter) 1 October 1-December 31, (quarter) 2 January 1-March 31, (quarter) 3 April 1-June 30, (quarter) 4 July 1-September 30 . On 6/16/25, Surveyor reviewed the facility's PBJ Staffing Data Report, CASPER Report 1705D for fiscal year 2024 which indicated quarter 2 (January 1-March 31) triggered for excessively low weekend staff. On 6/16/25, Surveyor requested timecard punches/staffing totals from Business Office Manager (BOM)-E. On 6/18/25 at 7:40 AM, Surveyor reviewed timecard punches/staffing totals for quarter 2. There were no low weekend hours and the facility was, on average, a minimum of ten nursing hours above the required amount. Surveyor also reviewed the Facility Assessment and noted the facility was staffed accordingly. On 6/18/25 at 9:38 AM, Surveyor interviewed BOM-E who indicated the facility reviews hours daily as a quality measure to ensure all hours are submitted correctly to the corporate office for submission to CMS. BOM-E was unsure why the PBJ report triggered for low weekend staffing and indicated BOM-E would obtain contact information for the employee who submitted the information. On 6/18/25 at 10:22 AM, Surveyor interviewed Director of Operations (DOO)-C who indicated the employee who submitted the information to CMS was on medical leave and unreachable. DOO-C indicated daily measures taken to ensure correct reporting include a report that indicates errors in the staffing totals. DOO-C indicated BOM-E will resubmit information to ensure staffing totals are correct. DOO-C was unsure why the PBJ report continued to show low weekend staffing and suspected there was an error in the reporting and timecard system with regard to agency staffing hours.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review, the facility did not maintain an infection prevention and control program designed to prevent the transmission of communicable disease and infection for 1 resident (R) (R37) of 3 sampled residents. R37 was on enhanced barrier precautions (EBP) due to a percutaneous endoscopic gastrostomy (PEG) tube. On 6/17/25, Licensed Practical Nurse (LPN)-I did not wear a gown while providing medication via R37's PEG tube. Finding include: The facility's Enhanced Barrier Precautions policy, revised 2/5/25, indicates: .EBP refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) that employs targeted gown and glove use during high-contact resident care activities .an order for enhanced barrier precautions will be obtained for residents with any of the following: wounds and/or indwelling medical devices . On 6/17/25, Surveyor reviewed R37's medical record. R37 was admitted to the facility on [DATE] and had diagnoses including acute gastrojejunal ulcer with perforation, pain, and a gastrostomy. R37's Minimum Data Set (MDS) assessment, dated 4/24/25, included a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R37 had intact cognition. R37 made R37's own medical decisions. On 6/17/25 at 7:50 AM, Surveyor observed LPN-I complete hand hygiene and don gloves. LPN-I pulled down R37's blankets, pulled up R37's shirt, and accessed R37's PEG tube to provide R37's AM medications. LPN-I did not don a gown prior to administering medication via R37's PEG tube. On 6/17/25 at 8:19 AM, Surveyor interviewed LPN-I who indicated LPN-I should have worn a gown while administering medication via R37's PEG tube. On 6/17/25 at 8:50 AM, Surveyor interviewed Director of Nursing (DON)-B who indicated LPN-I should have worn a gown while administering R37's medications.