

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525637	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/14/2026
NAME OF PROVIDER OR SUPPLIER Cornell Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE 320 N 7th St Cornell, WI 54732	
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 and interview, the facility did not store and follow proper sanitation and food handling practices to prevent foodborne illnesses for 41 residents who consume food out of 41 residents who reside at facility. The facility:-Did not ensure food in dry storage was properly stored in containers after opened and exposed to air and was not dated when opened.-Did not ensure all foods in resident refrigerator in common area was labeled and dated when opened for a possible 5 residents (R3, R17, R18, R19, R27).-Did not ensure juices and milk were dated when opened in resident dining room refrigerator.-Did not ensure food was a minimum of 6 inches off the floor in walk in freezer.-Did not ensure dietary staff properly contained hair within hair nets.-Did not ensure dietary staff did not directly handle food with bare hands.-Did not ensure temping of foods was done in a sanitary manner by wiping thermometers with alcohol prior to inserting into food. Findings:The facility policies, titled Food: Preparation and Food Storage, and Safe Handling for Foods from Visitors, state, Dining Services staff will be responsible for food preparation procedures that avoid contamination by potentially harmful physical, biological, and chemical contamination.All food items will be stored 6 inches above the floor.All foods will be stored, wrapped or in covered containers, labeled and dated.Residents will be assisted in properly storing and safely consuming food brought into the facility for residents by visitors.Label foods with the resident name and the current date.Daily monitoring for refrigerated storage duration and discard of any food items that have been stored for greater than 7 days.On 07/13/2026 at 6:00 AM, Surveyor observed a resident refrigerator/freezer in common area with the following:-A jar of pickles with R27's initials and not labeled with an opened date-A jar of opened olives not labeled with a resident name or opened date-An opened package of swiss cheese slices not labeled with a resident name or opened date-A clear plastic container with pasta and unknown sauce without a resident name or opened date-A partial container of ice cream with R3's initials and not labeled with an opened date in freezer-A partial box of popsicles and a container of ice cream, both labeled with a last name only that match 3 residents (R17, R18, R19) who share same last name, in freezer without an opened date. -Signage on outside refrigerator door informing staff to check refrigerator daily and to label and date all foods brought in for residents by family/visitors. On 07/13/2026 at 6:03 AM, Surveyor observed during an initial tour of facility kitchen:-A opened bag of butterscotch chips that was exposed to air and not labeled with opened date in dry food storage area-A partial opened box of pancake mix not labeled with opened date in dry food storage area-A partial bag of dried cranberries with an open date of 03/22/2026 in dry food storage area-A cardboard box containing 2 unopened bags of frozen vegetable blend on the floor of the walk-in freezerOn 07/13/2026 at 6:23 AM, Surveyor observed the following in refrigerator in resident dining room:-An opened and partial gallon jug of white milk not labeled with opened or to use by dates-A pitcher of orange juice not labeled with opened or to use by dates-Individual containers of prune juice (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	with no expiration datesOn 07/13/2026 at 8:19 AM and at 8:25 AM, Surveyor observed dietary cook (DC) D grab a slice of bread out of a bread bag with bare hands and place on a resident's plate. On 07/13/2026 at 8:20 AM, Surveyor observed dietary manager (DM) C, DC D and dietary aide (DA) F to all have several strands of hair protruding arounds sides and back of hair nets. DC D had 2 strands of loose, unattached hair observed on back of shirt. On 07/13/2026 at 12:00 PM, during Surveyor's observation of temperature checks on lunch foods in steamer table, DC D cleaned thermometer probe with alcohol wipe, placed probe onto counter surface, then picked probe up and inserted into food without cleaning probe again. Surveyor observed DC D repeat this action three times. On 07/14/2026 at 7:17 AM, Surveyor observed the refrigerator in resident dining room to have an opened, partial gallon jug of milk with no opened date. Surveyor also observed an unopened gallon of chocolate milk with expiration date of 07/13/2026. On 07/14/2026 at 7:49 AM, Surveyor asked DM C what the facility policy was for storage of all foods. DM C stated all foods needed to be labeled with a date when food was opened and dated for food to be used by. DM C confirmed the bag of butterscotch chips was exposed to air and should have been transferred to a covered container and labeled with opened date. DM C stated all foods needed to be at least 6 inches off of the floor and foods needed to be checked often for expiration dates. DM C confirmed food thermometers needed to be cleaned with alcohol prior to, in-between and after temping all foods and should not touch any other surfaces before being inserted into foods. DM C stated staff should have hair contained within hair nets and the facility hair nets were not optimal for long hair. DM C stated it was the floor and nursing staff's responsibility to check both the resident refrigerator in the common area and dining area for foods to be labeled, dated and disposed of. On 07/14/2026 at 10:40 AM, Surveyor asked Director of Nursing (DON) B whose responsibility it was at the facility for monitoring, labelling, dating and disposing of foods brought in by visitors for residents. DON B stated it was floor staff's responsibility to label any foods brought in by family/visitors for residents with the residents' name and date when brought in. DON B stated after 3 days of date, any food left in refrigerator is disposed of by staff. DON B confirmed there was more than one resident with same last name residing at the facility.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not ensure residents are free of any significant medication errors for one resident (R47) of 3 residents observed during medication administration in a sample of 13 residents. The facility failed to implement safe medication administration measures which include checking correct timing of a PRN (as needed) medication that could have led to an accidental overdose of a narcotic medication to R47 by giving it 2 hours early according to physician orders. Findings: The facility policy, titled Medication Administration General Guidelines, dated 01/2026, states, Verify medication is correct three (3) times before administering the medication; when pulling medication package from cart, when dose is prepared, and before dose is administered. the individual who administers the medication dose, records the administration on the resident's MAR (Medication Administration Record) immediately following the medication being given. R47 was admitted to the facility on [DATE] with diagnoses that include chronic pain syndrome and osteomyelitis of right foot and ankle. R47 has a BIMS score of 15 which means cognitively intact. On 07/13/2026, record review of R47's physician orders: Oxycodone HCO oral tablet 5 mg - Give 2 tablets by mouth every 6 hours as needed for pain scale of 7 to 10. Note: Oxycodone is a potent opioid analgesic used to manage moderate-to severe pain. Common side effects may include nausea, vomiting, drowsiness and dizziness. Severe risks include slow or shallow breathing (respiratory depression), extreme sedation, and overdose. On 07/13/2026 at 7:43 AM, Surveyor observed Licensed Practical Nurse (LPN) E prepare medications to administer to R47. Surveyor observed LPN E retrieve 2 tablets of oxycodone 5mg from pharmacy bubble packaging. Surveyor observed R47's electronic MAR to indicate last dose of Oxycodone was administered on 07/13/2026 at 4:32 AM in red lettering directly above a Y tab to document administration of medication. Prior to entering R47's room with the medications, Surveyor asked LPN E how it is determined when a last dose of PRN medication was given. LPN E then looked at R47's MAR and stated, Oh, it is too early for her to have oxycodone. On 07/14/2026 at 10:40 AM, Surveyor asked Director of Nursing (DON) B what the facility expectations were for safe administration of medications to residents. DON B stated nurses are to check all medications 3 times prior to administering a medication to a resident. Surveyor shared the concern with DON B that LPN E would have administered R47's oxycodone too early resulting in possible overdosing if Surveyor first had not asked LPN E how a PRN medication last dosing time was determined. DON B stated a pop-up alert will let nurses know if a PRN medication is attempting to be administered too early. Surveyor asked DON B if by checking the Y tab, if the electronic medical record's (EMR) intent of indicating the medication was already administered to a resident. DON B could not confirm that. DON B stated the medications are not actually documented until a Save tab is clicked on. Surveyor asked DON B if the practice to click on the Y tab prior to administering medications was consistent amongst all nursing staff and DON B could not confirm that. Surveyor asked DON B if some nurses administered medications first, then returned to the EMR and clicked on the Y, therefore not noticing a pop-up alert until the medication was already given. DON B confirmed it was a possibility. Surveyor asked DON B to demonstrate to Surveyor a pop-up alert for R47's oxycodone medication. Prior to DON B clicking on the Y to retrieve the pop-up alert on R47's oxycodone, Surveyor asked DON B if the last time PRN oxycodone was administered to R47 was visible in red lettering above the Y and DON B confirmed it was.		