STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525648	A. Building B. Wing	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Barron Care and Rehabilitation	660 E Birch Ave Barron, WI 54812

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, are reported immediately to the administrator of the facility and to other officials, including the State Survey Agency, in accordance with State law through established procedures for 1 of 4 sampled residents reviewed.-The facility staff did not immediately respond to R7's wanderguard alarm, and R7 eloped from the facility.-The facility did not report R7's elopement within two hours, as the allegation involved potential neglect.-The facility did not submit the misconduct incident report within five business days of discovery of the incident.The facility's policy titled, Elopement Prevention and Response, read in part, It is the policy of this facility to ensure that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk.2. Alarms are not a replacement for necessary supervision. Staff are to be vigilant in responding to alarms in a timely manner.d. Adequate supervision will be provided to help prevent accidents or elopements.Surveyor requested the facility's policy of reporting requirements but was not provided with this.R7 was admitted to the facility on [DATE]. Diagnoses included dementia with behavioral disturbance. R7 propelled wheelchair independently. R7's Power of Attorney (POA) was activated to assist with decision making.R7's Minimum Data Set (MDS) assessment, completed on 09/08/25, confirmed R7 scored 08/15 during Brief Interview for Mental Status (BIMS), indicating moderately impaired cognition. R7's MDS assessment revealed R7 presented with wandering behaviors placing R7 at significant risk of getting to a potentially dangerous place.R7's care plan included:-Resident will not leave building unattended Date Initiated: 08/27/2025 Revision on: 12/11/2025-One on one supervision. Date Initiated: 11/10/2025-Resident is at risk for elopement r/t to hx of wandering and exit seeking behaviors, impaired safety awareness. Date Initiated: 08/27/2025-Attempt to engage resident in pleasant, meaningful, purposeful enjoyable, resident centered activities, during episodes of constant wandering. Date Initiated: 08/27/2025-Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Date Initiated: 08/27/2025-Document wandering behavior and attempted interventions to provide resident with meaningful activities, validation, and relationship-based redirection in behavior note. Date Initiated: 08/27/2025-Provide structured activities: toileting, walking inside and outside with supervision, orientation strategies including signs, pictures and memory boxes. Date Initiated: 08/27/2025-WANDER ALERT: Wander guard on L wrist Check device for placement every shift. Check function daily. Date Initiated: 08/27/2025On 10/06/25 at 4:42 PM, the facility submitted an Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse report, identifying R7's elopement from the facility on 10/05/25 at 8:00 AM. The facility's report stated R7's wanderguard alarm worked properly at the time of the elopement but staff did not respond to the alarm (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	either due to not hearing the alarm or were busy with other residents preparing for breakfast.Staff located R7 outside the front doors of the facility on the sidewalk, sitting in his wheelchair. R7 stated he was getting some fresh air. R7 was brought back into the facility, and there were no injuries. Review of the temperatures on 10/05/25 at 8:00 AM, were approximately 70 .Staff reported the incident to Director of Nursing (DON) B. DON B reviewed the facility's elopement policy and determined the elopement was not reportable.On 10/06/25 at 9:00 AM, Nursing Home Administrator (NHA) A reviewed the incident and determined it reportable, due to lack of supervision. NHA A reported the incident to the State Agency (SA) at 4:42 PM, outside of the regulatory timeframe for reporting of incidents.On 10/16/25, the Office of Caregiver Quality (OCQ) contacted NHA A via email requesting the facility's misconduct incident report, required within five business days of the incident.On 10/20/25, NHA A responded to OCQ via email, stating he submitted the misconduct incident report on 10/10/25, and stating the system did not work properly. NHA A did not use the email system available when there are issues submitting reports to the Misconduct Incident Reporting (MIR) system.On 10/21/25, NHA A submitted the misconduct incident report to the SA.On 01/05/2026 at 12:46 PM, Surveyor interviewed Certified Nursing Assistant (CNA) C. CNA C was working on 10/05/25, and reported she heard the alarm going off, but the alarms are hard to hear. CNA C was not sure how long the alarm was going off but responded as soon as she could. CNA C reported she found R7 outside of the front doors of the facility, without injury. CNA C reported this to the nurse right away. CNA C stated she could not remember if she was interviewed or provided a written statement.On 01/07/2026 at 7:28 AM, Surveyor interviewed DON B. DON B stated she did review the elopement policy on the day of the incident and determined she did not think it was reportable as R7 did not leave the property. DON B stated on 10/6/25, NHA A changed his mind and reported the incident because the resident was an elopement risk and did leave the facility.On 01/07/25 at 11:56 AM, Surveyor interviewed NHA A. NHA A stated he reported the incident on 10/06/25 due to lack of supervision to prevent R7 from exiting the facility. NHA A stated the initial report was probably not submitted timely. NHA A stated he did submit the misconduct incident report within five days but had difficulty with the system.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not complete a thorough investigation of an injury for unknown origin for 1 of 1 resident (R)(R26) reviewed.On 12/06/25, R26 was noted to have an injury of unknown origin. Facility did not complete education for all staff on all potential causations of injury.This is evidenced by:R26 was admitted to the facility on [DATE] with pertinent diagnoses of vascular dementia severe with anxiety, Alzheimer's disease, fibromyalgia, weakness, contracture of muscle right thigh, contracture of muscle left thigh, contracture of muscle left lower leg, and contracture of muscle right lower leg.R26's most recent quarterly Minimum Data Set (MDS) assessment, dated 12/21/25 noted a Brief Interview of Mental Status (BIMS) score not completed due to resident rarely/never understood. R26 has ROM impairment of upper extremity on one side and impairment of lower extremities on both sides. R26 is dependent assist with all ADLs.R26's care plan, dated 03/04/21, with a target date of 12/23/25, states: Resident has ADL self-care deficit with interventions of transfer: hoyer and assist of 2.Of note: care plan does not indicate what size sling should be utilized for hoyer lift.Surveyor reviewed facility's self-report and noted:On 12/06/25, Registered Nurse (RN) E was notified by Certified Nursing Assistant (CNA) of bruises on R26's left arm and left breast and was noted to be pale in color and didn't eat breakfast. RN E notified Director of Nursing (DON) of findings and began investigation of injury of unknown origin and to monitor R26 for further changes. Interviews with staff and residents were completed. Provider and Power of Attorney (POA) were notified. On 12/08/25, R26 was noted to have worsening hematoma under left arm and left breast. Provider was notified and R26 was sent to ER for evaluation. ER determined R26 had an anterior left shoulder dislocation. ER contacted local police and Adult Protective Services. ER completed a shoulder reduction and R26 returned to facility with a left shoulder immobilizer in place until further orthopedic evaluation. Facility determined cause of injury was related to improper technique during upper body dressing of R26. Education was completed with CNA staff only on proper technique for dressing with impaired range of motion. Electronic total lift competency was completed with all nursing staff.Included in facility's investigation file was a disciplinary form for CNA D, dated 12/11/25. It noted improper transfer of resident with Hoyer lift. No additional information noted on what resident this was associated with. No additional education or training was documented for CNA D regarding safe transfers.Surveyor reviewed R26's hospital notes:12/08/25 Patient found to have a left shoulder dislocation. I do suspect that this was the cause to her left shoulder and arm ecchymosis.talked with nursing facility and they report the patient has had no falls or injuries. Patient is a hoyer lift. They suspected that she may have developed the bruising while they were transferring her. Spoke with patient's nephew her POA. He reports that he was not told of any injuries. I discussed with him my concern for potential abuse versus neglect as the patient is not ambulatory and has had no falls recently but has a dislocated shoulder. Adult protective Services and police were contacted to make a report.A police report was filed due to concern for possible elder neglect given the suspicious nature of the injury and delay in bringing her to care. However, this may have been sustained during a transfer or it could be related to her contractures and not related to overt abuse or neglect.Surveyor reviewed police report and noted:12/09/25: Officer spoke with facility staff and DON B regarding R26. DON B completed investigation and stated, they were not able to figure out how R26 obtained a dislocated shoulder and bruising on her elbow area. At this time, there is still no explanation to how R26 was injured. ER advised a report was generated and would be sent to appropriate agencies for follow-up. Facility was also advised of this information.Of note: no additional information was documented from police or other agencies.Surveyor reviewed facility's completed (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	education and noted all CNAs were educated on proper techniques for dressing residents with limited range of motion. No education was completed with licensed nursing staff. Hoyer lift competencies were completed with all nursing staff. No abuse prevention education was completed.Surveyor reviewed R26's mobility assessments and noted that on 12/17/24, 03/18/25, 06/16/25, and 09/20/25 no impairment to upper extremity range of motion was documented.Surveyor reviewed R26's therapy noted and noted:09/10/25 OT: Reason for referral - patient presents to therapy due to contractures, difficulty with staff completion of ADLs including bathing and dressing. Cause of functional change: deficits with ROM contractures in BUEs with difficulty of staff completing ADLs including bathing and dressing.11/04/25 OT: Discharge from services. R26 goal to improve left elbow extension to 20 degrees for increased ease of dressing and bathing.-09/10/25 (baseline) can't extend L elbow past 40 degrees.-10/22/25 25 degrees extension passive ROM L elbow.-11/04/25 full extension with tendon pressure applied.OT goal: Patient will improve L shoulder flexion to 105 degrees PROM/AROM for increased ease of bathing and dressing.-09/10/25 (baseline) 85 degrees L shoulder flexion-10/01/25 met goalOT goal: Patient will improve L shoulder flexion PrOM to 110 degrees for increased ease of bathing and dressing tasks.-09/10/25 (baseline) 105 degrees-10/22/25 105 degrees, increased spasticity/tone on L side compared to R side.-11/04/25 110 degrees PROM L shoulderDischarge instructions: Patient will complete PROM/AROM as able all joints BUEs 3x/week for development of appropriate RNP/FmP for contracture management, ease of caregiver self care tasks, skin hygiene.Surveyor reviewed R26's weekly summary skin condition assessments:11/05/25 no skin impairments; no contractures present11/12/25 no skin impairments; no contractures present11/17/25 no skin impairments; no contractures present11/25/25 no skin impairments; no contractures present12/02/25 no skin impairments; no contractures present12/09/25 no skin impairments; no contractures presentOn 01/06/26 at 1:10 PM, Surveyor interviewed CNA D regarding R26's incident. CNA D stated that on 12/06/25 she did not complete upper body dressing as she worked 6 AM - 2 PM that day and the overnight shift from prior completed this task. Surveyor asked CNA D if any bruises or skin changes were observed. CNA D stated not looking at R26's upper body at all that day. CNA D stated she reported to the nurse that day of R26 acting differently and looking pale but had no awareness of a bruise on the left side. Surveyor asked CNA D if R26 had difficulty putting on shirt due to contractures. CNA D stated sometimes, but it wasn't usually a problem. Surveyor asked CNA D if R26 had any falls or concerns with equipment malfunctioning. CNA D stated no. Surveyor asked CNA D if she received any training or education on proper sling sizing and Hoyer lift use. CNA D stated yes, for Hoyer lift, but could not recall appropriate sling size education being completed.On 01/06/26 at 3:25 PM, Surveyor interviewed RN E regarding incident. RN E stated he was notified by CNA on PM shift on 12/06/25 about a bruise on R26's left arm. RN E stated he assessed a small bruise on the back side of R26's arm and nothing else. RN E then notified the DON of bruise and stated he was told to monitor it for worsening. Surveyor asked if RN E if he documented the size and location. RN E stated he thought so, but wasn't sure. Surveyor asked RN E if daily skin assessments are completed by the nurse. RN E stated that CNAs inform the nurse if there are any changes in skin condition. Surveyor asked RN E if R26 had any recent falls or injuries he was aware of. RN E stated no. Surveyor asked if R26 had any upper extremity contractures that would make dressing difficult. RN E stated no, that prior to the incident R26's arms moved really good and he didn't notice any difficulties.On 01/07/26 at 7:43 AM, Surveyor interviewed DON B regarding incident. Surveyor asked how the facility determined the cause reported as improper technique with upper dressing. DON B stated it was an assumption based on the ER report stating it could be from contractures and their interviews did not uncover any falls or equipment misuse. Surveyor asked DON B to show documentation of R26 having (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	contractures prior to this incident. DON B was unable to provide documentation. Surveyor showed DON B the previous nursing documentation noting no contractures present. DON B stated being unaware of this. Surveyor asked DON B why a disciplinary form on CNA D was included in the facility's investigation file for the incident. DON B stated that during interview with CNA D, CNA D admitted to transferring R26 with the Hoyer lift by herself, and R26 was supposed to have 2 people assisting. Surveyor asked DON B if re-education on Hoyer lift transfers was completed with CNA D. DON B stated no because Hoyer lift competency had been completed and she did just fine. Surveyor asked DON B if it was possible that without noted contractures present in the upper extremities, was it then possible that actual neglect or some other action may have caused R26's injury. DON B stated yes that was why they completed education on dressing techniques with CNAs and did Hoyer lift competencies. Surveyor asked DON B if sling size education was completed with staff. DON B stated no, that a chart is in the utility room with the slings.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on observation, interview and record review, the facility did not ensure that 4 of 4 residents reviewed for falls (R5, R7, R10, and R26), received adequate supervision and assistance to prevent accidents.Findings: -The facility staff did not immediately respond to R7's wanderguard alarm, and R7 eloped from the facility. -The facility did not add a new intervention to R7 and R10's care plan after an accident. -The facility's documentation does not support R7 was 1:1 supervision.-The facility did not assess R26 for appropriate sling size based on manufacturer's recommendations.-The facility did not complete a thorough investigation after R5 had a fall with major injury to determine root cause and implement safety interventions.Example 1 The facility's policy titled, Elopement Prevention and Response, read in part, It is the policy of this facility to ensure that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. 2. Alarms are not a replacement for necessary supervision. Staff are to be vigilant in responding to alarms in a timely manner. d. Adequate supervision will be provided to help prevent accidents or elopements. R7 was admitted to the facility on [DATE], with diagnoses including dementia with behavioral disturbance. R7 propelled wheelchair independently. R7's Power of Attorney (POA) was activated to assist with decision making. R7's Minimum Data Set (MDS) assessment, completed on 09/08/25, confirmed R7 scored 08/15 during Brief Interview for Mental Status (BIMS), indicating moderately impaired cognition. R7's MDS assessment revealed R7 presented with wandering behaviors placing R7 at significant risk of getting to a potentially dangerous place. R7's care plan included: -Resident will not leave building unattended Date Initiated: 08/27/2025 Revision on: 12/11/2025 -One on one supervision. Date Initiated: 11/10/2025 -Resident is at risk for elopement r/t to hx of wandering and exit seeking behaviors, impaired safety awareness. Date Initiated: 08/27/2025 -Attempt to engage resident in pleasant, meaningful, purposeful enjoyable, resident centered activities, during episodes of constant wandering. Date Initiated: 08/27/2025 -Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Date Initiated: 08/27/2025 -Document wandering behavior and attempted interventions to provide resident with meaningful activities, validation, and relationship-based redirection in behavior note. Date Initiated: 08/27/2025 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Provide structured activities: toileting, walking inside and outside with supervision, orientation strategies including signs, pictures and memory boxes. Date Initiated: 08/27/2025 -WANDER ALERT: Wander guard on L wrist Check device for placement every shift. Check function daily. Date Initiated: 08/27/2025 On 10/06/25 at 4:42 PM, the facility submitted an Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse report, identifying R7's elopement from the facility on 10/05/25 at 8:00 AM. The facility's report stated R7's wanderguard alarm worked properly at the time of the elopement but staff did not respond to the alarm either due to not hearing the alarm or were busy with other residents preparing for breakfast. Staff located R7 outside the front doors of the facility on the sidewalk, sitting in his wheelchair. R7 stated he was getting some fresh air. R7 was brought back into the facility, and there were no injuries. Review of the temperatures on 10/05/25 at 8:00 AM, were approximately 70 degrees . Staff reported the incident to Director of Nursing (DON) B. On 10/05/25 at 9:17 AM, R7's progress notes read, Advised CNAs [Certified Nursing Assistants] to do an increased monitoring. Note, this was not added to R7's care plan until 11/10/25, 1:1 supervision was added to R7's care plan. Surveyor reviewed R7's progress notes and noted: -10/15/25, resident is just wandering the hallways. He is still on q15 min checks. He will be started on increased supervision. -10/16/25, Resident required increased supervision today. He was exit seeking most of the day today. -10/20/25, Resident needs increased supervision d/t exit seeking behaviors. -10/31/25, Resident stated being angry that he had to stay here. He stated he wanted to leave and walk out the door and wants to go home. -11/03/25, Later after supper he was trying to get out of the main door. But the door was locked. He was just pushing the door. -11/11/25, Resident does require increased supervision on all shifts d/t behaviors. -11/28/25, Resident requires increased supervision this shift. Resident was doing a lot of wandering/exit seeking this shift. -12/04/25, Resident did require increased supervision today, for wandering. Note, Surveyor was unable to find documentation to support R7's supervision was increased or R7 was placed on 15-minute checks or 1:1 from 10/05/25. On 11/24/25, an order was added to R7's Treatment Administration Record (TAR); Take report from CNA doing 1:1 supervision every shift. Document EVERY SHIFT on resident's mood and behavior. Note any (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	behaviors and interventions tried and whether they are successful or not. Document things that bother resident or set off behavior, every shift for behavior charting. Be specific including anything preceding his behavior and interventions tried and whether they are successful or not. D/c date 01/06/26. Note, 1:1 was added to R7's care plan on 11/10/25. Surveyor was unable to find documentation to support R7 was 1:1 from 11/10/25-11/24/25. Note, R7's nursing progress notes do not support documentation was completed daily and every shift on R7's mood and behaviors. Progress notes do not support R7 was 1:1 each day or shift. Surveyor reviewed Certified Nursing Assistant tasks and noted a 1:1 task for R7. Surveyor noted CNA staff documented 1:1 on: -12/11/25 -12/18/25 -12/23/25 -12/25/25 -12/31/25 During the survey period from 01/05/26-01/07/26, Surveyor did not observe R7 to have 1:1 supervision. On 01/05/2026 at 12:46 PM, Surveyor interviewed CNA C. CNA C was working on 10/05/25, and reported she heard the alarm going off, but the alarms are hard to hear. CNA C was not sure how long the alarm was going off but responded as soon as she could. CNA C reported she found R7 outside of the front doors of the facility, without injury. CNA C reported this to the nurse right away. CNA C stated she could not remember if she was interviewed or provided a written statement. CNA C stated R7 is 1:1 when it is needed, when [R7] has more behaviors or is exit seeking. CNA C stated staff know when R7 is 1:1 because it is given in shift report. CNA C did confirm R7 is not always a 1:1 supervision. On 01/07/2026 at 7:28 AM, Surveyor interviewed DON B. DON B stated R7 was 1:1 on PM shift M-F, and AM and PM shift on weekends, as there are more staff M-F to provide supervision during the AM shift. Surveyor discussed with DON B that documentation and staff interviews did not indicate 1:1 was consistently completed. DON B stated she would look, but did acknowledge there was lack of documentation. On 01/07/25 at 11:56 AM, Surveyor interviewed Nursing Home Administrator (NHA) A. NHA A stated he reported the incident on 10/06/25 due to lack of supervision to prevent R7 from exiting the facility. Example 2 The facility's policy titled, Falls Management, read in part, Add to temporary plan of care-include (continued on next page)

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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 - Some	interventions that are implemented. 5. Interventions must be put into place after any fall and documented in nurse's notes and care plan to prevent further incident. Interventions used must be different each time and if already in therapy cannot use them as an intervention. Falls will be discussed at morning meeting to ensure that all departments are aware of safety needs and interventions that are put into place to prevent future falls if appropriate. R10 was admitted to the facility on [DATE], diagnoses included Alzheimer's disease and history of falls. R10's MDS assessment completed on 05/02/25, confirmed R10 scored 06/10 during BIMS, indicating severely impaired cognition. R10 uses a wheelchair for mobility and requires assistance from staff with all transfers. R10's care plan included: The resident is at risk for further falls recent fall r/t weakness, deconditioning, hx of falls and unaware of safety needs. Date Initiated: 09/27/2021 Revision on: 11/19/2022 -Resident will have no serious injury from a fall Date Initiated: 09/27/2021 Revision on: 08/01/2025 -Pressure alarms in W/C and recliner. Date Initiated: 01/29/2025 -Ensure that the resident is wearing appropriate-fitting clothing and footwear that fits well when ambulating or mobilizing in w/c. Date Initiated: 09/27/2021 Revision on: 11/06/2024 -Auto locks applied to W/C. Date Initiated: 10/02/2024 -Dycem cushion in wheelchair to prevent from sliding forward. Date Initiated: 10/07/2024 -Encourage participation in activities that will increase strength and mobility. Date Initiated: 09/27/2021 -Evaluate, interview and document resident physical condition and cognitive status. Observe environment to identify any potential factors that could contribute to a fall, such as lighting, uneven/slippery/cluttered floor surfaces, improper footwear, failure to use assistive devices, etc. Remove any potential causes or hazards, if possible. Educate resident and caregivers of potential fall hazards for the resident. Date Initiated: 09/27/2021 -Invite, encourage, and assist resident to activities of preference. Date Initiated: 09/27/2021 -Invite, encourage, and assist the resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility and balance. Date Initiated: 09/27/2021 -Make sure that brakes on bed are locked when resident is in bed. Date Initiated: 09/27/2021 -Provide resident with safe environment: clutter free; support/assistive devices are available and in good repair; personal items and call device within reach; non-glare soft lighting at night, etc. Date Initiated: 09/27/2021 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525648	A. Building B. Wing	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Barron Care and Rehabilitation	660 E Birch Ave Barron, WI 54812

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-PT to evaluate and treat as ordered. Date Initiated: 09/27/21 -Remind resident to use assistive devices and to use call device for assistance. Date Initiated: 09/27/21 On 06/15/25, R10 sustained a witnessed fall in her room. R10 was evaluated in the emergency room and determined to have no injuries. R10's progress notes read, Nurse was called into room when entered room resident and CNA where they were tangled up laying on the floor CNA was able to get repositioned and move away from the resident when attempted to help her she became vocal about her Ass hurting and when nurse questioned her she became verbally abusive. attempted to straighten out left leg and she screamed in pain noted left leg was shorter than right leg it was assisted that she would be transferred to the Hospital ER. placed call to POA and left message called Poa Alt and she said it was OK to send her and she wanted a bed hold for her room Called 911 and Hospital and updated them. placed call to DON and updated her Ambulance arrived and transported resident to ER. Surveyor noted R10's care plan was not updated after the fall, to help prevent further falls or accidents. On 01/07/26 at 7:28 AM, Surveyor interviewed DON B. Surveyor noted to DON B that R10's care plan did not reflect interventions after the fall. DON B did not have additional statements related to this. Example 3 R26 was admitted to the facility on [DATE] with pertinent diagnoses of vascular dementia severe with anxiety, Alzheimer's disease, fibromyalgia, weakness, contracture of muscle right thigh, contracture of muscle left thigh, contracture of muscle left lower leg, and contracture of muscle right lower leg. R26's most recent quarterly Minimum Data Set (MDS) assessment, dated 12/21/25, noted a Brief Interview of Mental Status (BIMS) score not completed due to resident rarely/never understood. R26 has ROM impairment of upper extremity on one side and impairment of lower extremities on both sides. R26 is dependent assist with all ADLs. R26's care plan, dated 03/04/21, with a target date of 12/23/25, states: Resident has ADL self-care deficit with interventions of transfer: hoyer and assist of 2. Of note: care plan does not indicate what size sling should be utilized for Hoyer lift. Surveyor reviewed Certified Nursing Assistant (CNA) Kardex and noted for R26 transfer assist with Hoyer. No sling size noted. Surveyor reviewed R26's therapy notes and noted no indication for sling size for use with Hoyer transfers. On 01/05/26 at 1:09 PM, Surveyor observed 2 staff assisting R26 with Hoyer lift transfer from broda chair to bed. R26 was observed in sling with black handles. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor observed Volaro Hoyer lift used for transfers had a sizing chart attached to machine. The sizing chart noted that color of sling handles indicate size and black handles were a size large and intended for patients weighing 200-325 lbs. Surveyor reviewed R26's weights and noted between 10/16/25 – 01/06/26, R26 weighed between 159 – 164 lbs. Surveyor reviewed the Volaro manufacturer's guidelines for choosing sling size and noted, .to determine the proper sling size, lay a sling across the persons chest. If it's the proper size sling, you will note 2-8 inches of extra material extended past the side of each arm. Additionally, the sling size chart noted that each size sling had a corresponding weight, shoulder and hip measurement to determine sizing. Of note: no documentation was noted in R26's medical record to indicate shoulder and hip measurements to determine sling size. On 01/06/26 at 1:10 PM, Surveyor interviewed CNA D regarding R26's sling size. CNA D stated she thinks R26 uses an XL sling size. Surveyor asked CNA D how staff know which size sling to use. CNA D stated they look at the size of the resident or are told by the nurse. Surveyor asked CNA D if staff receive education on choosing the appropriate sling size for Hoyer lifts. CNA D stated no she couldn't remember any training. On 01/06/26 at 3:25 PM, Surveyor interviewed Registered Nurse (RN) E regarding R26's sling size. RN E stated he thought it was a medium. Surveyor asked RN E how staff know what size sling to use. RN E stated they go by weight and the positioning of the sling with resident's body. Surveyor asked RN E if staff receive training on choosing appropriate sling size. RN E stated there is a chart in the utility closet where the slings are stored that tells which size sling to use based on weight but couldn't recall any formal education or training. On 01/07/26 at 8:06 AM, Surveyor interviewed Director of Nursing (DON) B regarding sling sizes. Surveyor asked DON B if training and education is completed with staff regarding sling sizing. DON B stated inability to recall specific training for slings but that Hoyer transfer lift safety training is completed. Surveyor asked DON B if she was aware of manufacturer's guidelines for sling sizes. DON B stated no. Example 4 R5 was admitted to the facility on [DATE] with pertinent diagnoses of Alzheimer's disease with late onset, dementia with anxiety, dependence on supplemental oxygen, long-term use of anticoagulants, atrial fibrillation, and weakness. R5's most recent significant change Minimum Data Set (MDS) assessment, dated 11/07/25, noted a Brief Interview for Mental Status (BIMS) score was not assessed due to resident rarely/never understood and had no memory/recall ability. R5 had impaired ROM on one side of lower extremity and dependent assist with all ADLs related to transfer and hygiene. R5 had one fall with major injury. R5's care plan, dated 07/24/25, with a target date of 02/18/25, states: Resident has ADL self-care deficit with interventions of encourage resident to use call light to request assistance and provide reminders as needed (07/24/25) (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R5's care plan, dated 07/24/25, with a target date of 02/18/26, states: Resident is at risk for falls with interventions of ALARM: pressure alarm to chair and bed (08/18/25), ensure resident is wearing appropriate-fitting clothing and footwear that fits well when ambulating or mobilizing in w/c (07/24/25), remind resident to use assistive devices and to use call device for assistance as needed (07/24/25). Of note: no revisions to care plan interventions were noted after 08/18/25. R5's fall assessments: 07/24/25 19: at risk 08/07/2517: at risk 08/21/25 15: at risk 11/07/25 17: at risk Surveyor reviewed R5's falls: On 10/30/25 at 8:24 AM, R5 had an unwitnessed fall in room; res had fallen onto floor w/head looking up toward ceiling out of recliner chair. R5 did have mild pain to R leg/hip area. No wounds. Res stated she was trying to get up and her slippers slipped. Family, DON, provider notified. Sent to ER via ambulance for eval. ER documentation: 10/30/25 – CT abdomen w/IV contrast – Impression: 1. Acute comminuted fracture of the greater trochanter of right proximal femur. CT head w/o contrast – No acute infarct, hemorrhage, or mass effect. Surveyor reviewed facility's investigation of incident and noted no determination of root cause of incident and no new safety interventions were implemented. On 01/07/26 at 8:01 AM, Surveyor interviewed DON B regarding R5's fall. DON B stated she believed the new intervention of an additional chair alarm was added to alert staff quicker if R5 attempted to transfer self without assist but acknowledged this wasn't updated in R5's care plan. Surveyor asked DON B for additional documentation that this incident was fully investigated and reviewed by IDT. DON B stated no additional documentation was available, and it was not documented.