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	10/09/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31086 Based on observation, interview and record review, the facility did not ensure residents (R) were treated with respect and dignity and cared for in a manner to enhance their quality of life. Facility staff used clothing protector to wipe resident's face while assisting to eat. This affected 3 of 3 residents observed. (R13, R18, and R17) This is evidenced by: Example 1 Facility's policy titled Resident [NAME] of Rights documented in part: Quality of Life, 19. Dignity, The facility must promote and care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. R13's medical record documented current diagnoses including in part, Alzheimer's disease, major depressive disorder, dysphagia following cerebrovascular disease, CKD stage 3A, dementia, and mild protein-calorie malnutrition. R13's Minimum Data Set (MDS) quarterly assessment dated [DATE] documented R13 having severe impaired cognition and dependent on staff for meal assistance. On 10/08/24 at 8:48 a.m., Surveyor observed Certified Nursing Assistant (CNA) I assist R13 with breakfast meal. R13 receives meal pureed in cups and staff assist R13 to drink the meal. While CNA I was assisting R13 with breakfast meal, CNA I used R13's clothing protector to clean R13's mouth. This continued for the entire breakfast meal. Surveyor observed an unused napkin on the table that was provided with R13's meal. Example 2 R18's medical record documented current diagnoses including in part, vascular dementia, hemiplegia and hemiparesis cerebral infarction, dysphagia, osteomyelitis left elbow, pressure ulcer stage 3 left elbow, type 2 diabetes mellitus, heart failure, and benign prostatic hyperplasia with lower urinary tract infections. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525648	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/09/2024
NAME OF PROVIDER OR SUPPLIER Barron Care and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 660 E Birch Ave Barron, WI 54812	

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R18's MDS assessment, dated 01/11/24, identified on admission that R18 had a Brief Interview for Mental Status (BIMS) score of 08. This indicated R18 had moderate cognitive impairment. The MDS assessment also identified R18 required total dependent assistance for eating. On 10/08/24 at 8:52 a.m., Surveyor observed CNA E assisting R18 with breakfast meal. While CNA E was assisting R18 with the breakfast meal, CNA E was using R18's clothing protector to clean R18's mouth. Surveyor observed an unused napkin on the table that was provided with R18's meal. Example 3 R17 was admitted to the facility on [DATE] with diagnoses including in part, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, and dysphagia. R17's MDS assessment, dated 08/17/24, identified that R17 had a BIMS score of 12. This indicated R17 had moderate cognitive impairment. The MDS assessment identified R17 had impairment to one side of the upper extremities and required supervision and touching assistance with eating meals. On 10/08/24 at 8:56 a.m., Surveyor observed CNA D approach R17 and asked if R17 was completed with breakfast. CNA D assisted taking off R17's clothing protector and wiped R17's mouth with the clothing protector. Surveyor observed R17 had a paper tissue and napkin in lap which R17 had used prior to wipe mouth. On 10/09/24 at 10:53 AM, Surveyor interviewed R17 about the observation of staff wiping her face with the clothing protector. R17 stated she did not like when staff use the clothing protector to wipe her face. R17 indicated she uses a napkin or tissue to wipe her face and it was not dignified to use the clothing protector. On 10/09/24 at 12:30 p.m., Surveyor interviewed Interim Director of Nursing (DON) H and asked if staff are to use clothing protector to wipe residents' mouths. Interim DON H indicated staff should be using a napkin. Education will be provided to staff.

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48793 Based on record review, observations and staff interview, the facility did not ensure 1 resident (R) (R18) of 15 sampled residents was reasonably accommodated with access to a call light. R18 was observed in R18's room without access to a call light or means to notify staff if assistance was needed. Findings include: R18 was admitted to the facility on [DATE] with diagnoses including in part, vascular dementia, hemiplegia and hemiparesis cerebral infarction, dysphagia, osteomyelitis left elbow, pressure ulcer stage 3 left elbow, type 2 diabetes mellitus, heart failure, and benign prostatic hyperplasia with lower urinary tract infections. R18's Minimum Data Set (MDS) assessment, dated 09/13/24, identified R18 had a Brief Interview for Mental Status (BIMS) score of 08. This indicated R18 had moderate cognitive impairment. The MDS assessment also identified R18 required total dependent assistance of two people for bed mobility, taking on and off footwear, rolling left to right, sit to lying, chair to bed, toileting, eating, and for transfers. Observations: On 10/07/24 at 9:48 AM, Surveyor observed R18 lying in bed. R18 appeared to be sleeping, but Surveyor observed R18 to have contracted hands bilaterally. Surveyor observed R18's bed positioned high and soft touch call light above R18's head draped underneath R18's pillow. Surveyor observed soft touch call light not in reach. On 10/07/24 at 9:56 AM, Surveyor observed R18 yelling for assistance from R18's room. On 10/07/24 at 10:07 AM, Surveyor observed Certified Nurse Assistant (CNA) F enter R18's room. R18 indicated R18 was cold and needed a blanket. CNA F gave R18 a blanket and exited R18's room. Surveyor observed R18's soft touch call light not in reach, draped underneath's R18's pillow at top of bed. On 10/07/24 at 10:13 AM, Surveyor interviewed R18. R18 indicated that R18 has complaints of pain in his leg, uncomfortable, and cold. R18 stated, usually uses call light but doesn't know where it is. Surveyor observed R18's soft touch call light not in reach, draped underneath's R18's pillow at top of bed. On 10/07/24 at 10:16 AM, Surveyor stopped Licensed Practical Nurse (LPN) G in hallway to inform LPN G of R18's request of being in pain and cold. LPN G entered R18's room and asked what R18 needed. R18 complained of being cold and wanting to get up out of bed. LPN G exited R18's room, met CNA J down the hallway and instructed CNA J to get R18 out of bed. Surveyor observed R18's soft touch call light not in reach, draped underneath's R18's pillow at top of bed. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/07/24 at 10:20 AM, Surveyor observed R18 yelling for assistance from R18's room. On 10/07/24 at 10:23 AM, Surveyor observed CNA D enter R18's room and ask R18 what R18 needed. R18 stated that R18 wants to get up out of bed. CNA D indicated to R18 that staff just laid R18 down in bed and would get R18 up before lunch. Surveyor observed R18's soft touch call light not in reach, draped underneath's R18's pillow at top of bed. On 10/08/24 at 9:05 AM, Surveyor observed R18 in wheelchair in room with call light attached. R18 utilized call light for assistance. CNA D entered and asked R18 what was needed. R18 indicated that R18 wanted to lay down in bed. On 10/08/24 at 9:08 AM, Surveyor observed CNA J and CNA D enter R18's room to transfer with Hoyer. On 10/08/24 at 9:18 AM, Surveyor observed R18 on back lying in bed. Surveyor observed call light lying on right side of R18 underneath R18's back shoulder not in reach. Surveyor heard R18 yell out for help. On 10/08/24 at 10:26 AM, Surveyor observed CNA J and CNA D enter R18's room and reposition R18 to right side slightly with pillow under left side. Surveyor observed call light lying on right side of R18 underneath R18's back shoulder not in reach. On 10/08/24 at 11:19 AM, Surveyor observed R18 lying on right side slightly with pillow under left side. R18's wife was in visiting R18. Surveyor observed call light lying on right side of R18 underneath R18's back shoulder not in reach. On 10/08/24 at 2:12 PM, Surveyor observed R18 lying in bed on back. R18's wife was in visiting R18. Surveyor observed call light lying on right side of R18 underneath R18's back shoulder not in reach. On 10/08/24 at 2:43 PM, Surveyor observed R18 lying in bed on back. R18's wife was in visiting R18. Surveyor observed call light lying on right side of R18 underneath R18's back shoulder not in reach. On 10/08/24 at 3:04 PM, Surveyor observed R18 lying in bed on back. R18's wife was in visiting R18. Surveyor observed call light lying on right side of R18 underneath R18's back shoulder not in reach. On 10/09/24 at 9:35 AM, Surveyor observed R18 lying in bed with pillow under left side. Surveyor observed call light lying on right side of R18 above R18's right shoulder not in reach. On 10/09/24 at 10:20 AM, Surveyor showed CNA D R18's call light and asked if it was in reach for R18 at this time. CNA D indicated the call light was not in reach for R18. CNA D moved call light down and over unto abdomen where R18 could reach call light. CNA D indicated that call light should be within reach for R18, which is usually placed on abdomen where R18 can reach appropriately. Surveyor asked CNA D why R18's call light was out of reach for the past 3 days. CNA D indicated that CNA D was unaware the call light was not in reach everyday but that sometimes we get busy, we forget. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/09/24 at 10:24 AM, Surveyor interviewed Interim Director of Nursing (DON) H and asked about call light usage with residents and expectation of offering call light services. Interim DON H indicated expectation is that every resident receives capabilities to utilize call lights. Interim DON H indicated all residents should have their call lights in reach in case they need assistance.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31086 Based on interview and record review, the facility did not notify the resident/representative in writing of the reason for the transfer/discharge for 5 of 6 residents reviewed who were discharged (R10, R14, R25, R8, R15). This is evidenced by: The facility's policy titled Resident [NAME] of Rights documented, in part: 14. Transfer and Discharge .Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident, of the transfer or discharge and the reasons, proposed date and location of transfer; record the reasons in the resident's clinical records; and include in the notice . Example 1 R10 was admitted to the facility on [DATE]. R10's medical record documented diagnoses in part, dementia with behavioral disturbance, Alzheimer's, Parkinson's, UTI, sepsis, infectious gastroenteritis, dysphagia, and CVA. R10 was transferred to the emergency department on 04/26/24 for right lower quadrant pain and was admitted to the hospital. Surveyor requested a copy of the notice for reason of transfer that was given to R10's legal representative. Director of Nursing (DON) B indicated no notice was given. Example 2 R14 was admitted to the facility on [DATE]. R14's medical record documented diagnoses in part: fracture part of neck of right femur, dislocation of internal right hip prosthesis, muscle weakness, chronic lymphocytic leukemia of b-cell type not having achieved remission, peripheral venous insufficiency, dementia mild with behavioral disturbance, pain, repeated falls, dizziness and giddiness, and anxiety. The Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 07. This indicated R14 had severe cognitive impairment. The MDS documented R14 had inattention and disorganized thinking. R14's medical record documented transfer to the emergency roiagnom on [DATE], 06/25/24, and 07/03/24. The medical record did not document a written reason for transfer notice was given to R14's legal representative. Surveyor requested a copy of the notice for reason of transfer that was given to R14's legal representative. Director of Nursing (DON) B indicated no notice was given. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/08/24 at 1:30 PM, Surveyor interviewed Interim Director of Nursing (DON) H about the written notices of transfer not being done. Interim DON H stated he talked with Social Services (SS) K and asked if SS K was doing the notices. SS K told Interim DON H that she was not doing the notices and DON B was doing the notices. Interim DON H indicated the social worker should be following up with the notices. Surveyor explained the facility's notices include the reason for transfer along with the bed hold notice and asked if the reason for transfer was provided in another manner. Interim DON H indicated was not aware of the written notification of transfer. On 10/08/24 at 2:32 PM, Surveyor interviewed SS K about the written notice of transfer. SS K stated she had not given residents or representatives written notices of transfers. SS K stated nursing had done the portion of giving the notices and the last DON was doing the notices and following up. 40181 Example 3 Record review identified R25 had a change in condition with shortness of breath and chest pain noted on 06/08/24. An on-call provider was notified and R25 was transferred to the emergency room and later admitted to the hospital. R25 remained in the hospital until 06/11/24. On further record review, Surveyor was unable to find a written notice of reason for transfer provided to R25's representative. 48793 Example 4 R8 was admitted to the facility on [DATE] with the following diagnoses in part, diabetes mellitus type 2, candidal sepsis, acute pyelonephritis, chronic kidney disease, and muscle weakness. Record review identified R8 was hospitalized on [DATE] - 08/30/24 due to urosepsis. Surveyor was unable to locate a written notice of discharge/transfer form for this hospitalization on R8's medical record. On 10/09/24 at 9:29 AM, Surveyor requested a copy of the written notice of discharge or transfer and documentation of ombudsman notification for R8's transfer to the hospital on 08/22/24. On 10/09/24 at 2:16 PM, Interim DON H reported they did not do a written notice of transfer form for R8's hospital transfer. DON B stated they are starting a process to fix this non-compliance. 49353 Example 5 R15 was admitted to the facility on [DATE] with pertinent diagnoses of diabetes mellitus, atrial flutter, and congestive heart failure. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R15's Minimum Data Set (MDS) assessments indicate that R15 was discharged to the hospital on 09/05/24 and returned to the facility on [DATE]. Nurse note dated 09/05/24 stated that R15 was sent to the Emergency Department (ED) via ambulance for vomiting. Nurse note dated 09/07/24 stated that R15 was admitted to the hospital for pneumonitis due to inhalation of food/vomit. On 10/08/24, Surveyor was unable to locate a written notice of discharge/transfer form for this hospitalization . On 10/08/24 at approximately 1:00 PM, Surveyor requested a transfer notice from Interim Director of Nursing (DON) B for R15's transfer to the hospital on 09/05/24. Interim DON B stated inability to locate a transfer notice.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31086 Based on interview and record review, the facility failed to ensure that written bed hold notice required for facility-initiated transfers was given to the residents or resident representatives for 5 of 6 residents reviewed for hospitalization (R10, R14, R25, R8, R15) This is evidence by: The facility's policy titled Bed Hold & Return to Facility with revised date of 05/03/24 documented, in part: It is the policy of this facility that residents who are transferred to the hospital or go on a therapeutic leave are provided with written information about the State's bed hold duration and payment amount before the transfer. Example 1 R10 was admitted to the facility on [DATE]. R10's medical record documented diagnoses in part, dementia with behavioral disturbance, Alzheimer's, Parkinson's, UTI, sepsis, infectious gastroenteritis, dysphagia, and CVA. R10 was transferred to the emergency department on 04/26/24 for right lower quadrant pain and was admitted to the hospital. Surveyor requested a copy of the bed hold notice that was given to R10's legal representative. Director of Nursing (DON) B indicated no notice was given. Example 2 R14 was admitted to the facility on [DATE]. R14's medical record documented diagnoses in part: fracture part of neck of right femur, dislocation of internal right hip prosthesis, muscle weakness, chronic lymphocytic leukemia of b-cell type not having achieved remission, peripheral venous insufficiency, dementia mild with behavioral disturbance, pain, repeated falls, dizziness and giddiness, and anxiety. The Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 07. This indicated R14 had severe cognitive impairment. The MDS documented R14 had inattention and disorganized thinking. R14's medical record documented transfer to the emergency roiagnom on [DATE], 06/25/24, and 07/03/24. The medical record did not document a written bed hold notice was given to R14's legal representative. Surveyor requested a copy of the bed hold notice that was given to R14's legal representative. Director of Nursing (DON) B indicated no notice was given. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/08/24 at 1:30 PM, Surveyor interviewed Interim Director of Nursing (DON) H about the written bed hold notices not being done. Interim DON H stated he talked with Social Services (SS) K and asked if SS K was doing the notices. SS K told Interim DON H that she was not doing the notices and DON B was doing the notices. Interim DON H indicated the social worker should be following up with the notices. On 10/08/24 at 2:32 PM, Surveyor interviewed SS K about the written bed hold notice being given to residents or representatives. SS K stated she had not given residents or representatives written bed hold notices. SS K stated nursing had done the portion of giving the notices and the last DON was doing the notices and following up. 40181 Example 3 Record review identified R25 had a change in condition with shortness of breath and chest pain noted on 06/08/24. An on-call provider was notified and R25 was transferred to the emergency room and later admitted to the hospital. R25 remained in the hospital until 06/11/24. On further record review, Surveyor was unable to find a written bed hold notice provided to R25's representative. 48793 Example 4 R8 was hospitalized from 07/30/24 to 08/07/24 for kidney stone blockage. R8 was hospitalized from 08/22/24 - 08/30/24 due to urosepsis. No written notice of bed hold policy was identified during review of R8's medical record. Surveyor requested a copy of the written notice of bed hold policy. On 10/09/24 at 2:16 PM, Interim DON H reported they did not do a written notice of transfer form for bed hold. DON B stated they are starting a process to fix this non-compliance. 49353 Example 5 R15 was admitted to the facility on [DATE] with pertinent diagnoses of diabetes mellitus, atrial flutter, and congestive heart failure. R15's Minimum Data Set (MDS) assessments indicate that R15 was discharged to the hospital on 09/05/24 and returned to the facility on [DATE]. Nurse note dated 09/05/24 stated that R15 was sent to the Emergency Department (ED) via ambulance for vomiting. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nurse note dated 09/07/24 stated that R15 was admitted to the hospital for pneumonitis due to inhalation of food/vomit. On 10/08/24 at approximately 1:00 PM, Surveyor requested bed hold notice documentation for R15 provided to the resident and/or representative at the time of the transfer or within 24 hours of the transfer. Interim Director of Nursing (DON) H stated inability to locate bed hold notification provided to the resident and/or representative at the time of the transfer or within 24 hours of the transfer.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48793 Based on observation, interview and record review, the facility did not develop and initiate a comprehensive care plan with targeted interventions for a resident to maintain baseline Activities of Daily living (ADL)s. This occurred for 2 of 15 residents (R) reviewed for care planning, (R17 and R14) Findings include: Example 1 R17 was admitted to the facility on [DATE] with diagnoses including in part, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, dysphagia, atherosclerotic heart disease, essential hypertension, and osteoarthritis of left knee. R17's Minimum Data Set (MDS) assessment, dated 08/17/24, identified that R17 had a Brief Interview for Mental Status (BIMS) score of 12. This indicated R17 had moderate cognitive impairment. The MDS assessment also identified R17 required total dependent assistance of two people for bed mobility, taking on and off footwear, rolling left to right, sit to lying, chair to bed, toileting, and for transfers. On 10/07/24 at 9:08 AM, Surveyor interviewed R17. R17 indicated that R17 had a stroke and now has left arm and left leg weakness from stroke. R17 indicated that R17 uses a Hoyer lift to transfer. R17 indicated that R17 feels R17 has not received appropriate services to maintain some independence and now R17 is totally reliant on staff for all cares. Surveyor reviewed R17's Physical Therapy (PT) notes, which state in part: On 03/17/24, PT recommends discharging R17 from PT and continuing with a restorative range of motion program for R17's left upper arm and left lower extremity. Surveyor reviewed R17's care plan initiated on 06/03/22 and revised on 05/23/23. Surveyor did not find a restorative range of motion care plan or interventions in place for R17. On 10/09/24 at 12:46 PM, Surveyor interviewed Interim Director of Nursing (DON) H and asked about a restorative range of motion care plan for R17. Interim DON H indicated Interim DON H was unaware of a restorative range of motion program ordered in March for R17. Interim DON H indicated that expectation would be if PT recommended a restorative range of motion program for R17 that R17's care plan would be updated to show the interventions and goals for the restorative range of motion. Surveyor indicated to Interim DON H that Surveyor could not find a care plan for restorative range of motion R17's care plan. Interim DON H indicated there is no restorative range of motion care plan for R17, but that Interim DON H would update R17's care plan to show the recommendations from PT. 31086 Example 2 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R14 was admitted to the facility on [DATE]. R14's medical record documented diagnoses in part: fracture part of neck of right femur, dislocation of internal right hip prosthesis, muscle weakness, chronic lymphocytic leukemia of b-cell type not having achieved remission, peripheral venous insufficiency, dementia mild with behavioral disturbance, pain, repeated falls, dizziness and giddiness, and anxiety. The Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 07. This indicated R14 had severe cognitive impairment. R14 had inattention and disorganized thinking. The MDS documented R14 had impairment to one side of the lower extremities. R14 is dependent for transfers, toileting hygiene, showering, oral care, lower body dressing, bed mobility to roll side to side and sit to lying partial to moderate assist. Surveyor reviewed R14's comprehensive care plans. A plan of care for activities of daily living was not developed to address R14's personal preferences and dependent need on staff for assistance with showering, dressing, oral care, personal hygiene, and bed mobility. On 10/09/24 at 12:32 p.m., Surveyor interviewed Interim DON H about R14's comprehensive activities of daily living plan of care. DON H indicated understanding that resident's care plans are not up to date.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31086 Based on record review and interview, the facility did not review and revise comprehensive care plans for falls, incontinence, and activities of daily living for 2 of 15 residents (R)14 and R17). This is evidenced by: Example 1 R14 was admitted to the facility on [DATE]. R14's medical record documented diagnoses in part: fracture part of neck of right femur, dislocation of internal right hip prosthesis, muscle weakness, chronic lymphocytic leukemia of b-cell type not having achieved remission, peripheral venous insufficiency, dementia mild with behavioral disturbance, pain, repeated falls, dizziness and giddiness, and anxiety. The Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 07. This indicated R14 had severe cognitive impairment. The MDS documented R14 had impairment to one side of the lower extremities. R14 is dependent for transfers, toileting hygiene, showering, oral care, lower body dressing, bed mobility to roll side to side and sit to lying partial to moderate assist and incontinent of bowel and bladder. Review of R14's medical record documented a fall on 06/13/24 with new intervention of a fidget blanket to decrease anxiety. Surveyor reviewed R14's comprehensive care plan for falls and the intervention was not included. R14 was hospitalized and returned to the facility on [DATE] with a non-weightbearing status. Review of R14's bladder incontinence care plan documented resident to request assistance as needed with ambulation to the bathroom. The care plan was not updated to non-weightbearing status and when incontinence cares are to be completed. On 10/09/24 at 12:32 p.m., Surveyor interviewed Interim Director of Nursing (DON) H about R14's comprehensive fall and incontinence plan of care not updated to R14's current condition. DON H indicated understanding that resident's care plans are not up to date. 48793 Example 2 R17 was admitted to the facility on [DATE] with diagnoses including in part, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, dysphagia, atherosclerotic heart disease, essential hypertension, and osteoarthritis of left knee. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R17's Minimum Data Set (MDS) assessment, dated 08/17/24, identified that R17 had a Brief Interview for Mental Status (BIMS) score of 12. This indicated R17 had moderate cognitive impairment. The MDS assessment also identified R17 required total dependent assistance of two people for bed mobility, taking on and off footwear, rolling left to right, sit to lying, chair to bed, toileting, and for transfers. Surveyor reviewed R17's activities of daily living care plan initiated on 06/03/22 and revised 05/23/23, in part: -Bed mobility revised on 06/20/22 the resident repositions independently when in bed. -Dressing revised on 06/20/22: Resident is able to participate in dressing tasks. -Transfer revised 08/28/23: The resident is able to transfer with the EZ stand. Surveyor reviewed R17's ADL care plan and did not find R17's ADL care plan revised to implement new interventions for R17's change in ADL needs. Surveyor observed during the 3-day survey from 10/07/24-10/09/24 that R17 is totally dependent on staff for all transfers in and out of bed, repositioning in wheelchair and bed, and ADL cares. R17 uses a hoyer lift for transfers. On 10/09/24 at 12:46 PM, Surveyor interviewed Interim DON H and asked why R17's ADL care plan was not updated to meet R17's new ADL function as documented from R17's MDS on 08/17/24. Interim DON H indicated Interim DON H was unaware that R17's ADL care plan was not updated. Interim DON H indicated that Interim DON H did not know that R17's ADL care plan still states R17 is transferred via EZ-stand and assists with dressing. Interim DON H indicated that R17's ADL care plan will be updated to show that R17 is total dependent as the MDS states from 08/17/24 and that R17 uses Hoyer lift to transfer instead of EZ-stand.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31086 Based on observation, interview and record review, the facility did not ensure 1 of 10 residents (R14) who are unable to carry out activities of daily living receive the necessary services for toileting and to maintain good personal hygiene. This is evidenced by: R14 was admitted to the facility on [DATE]. R14's medical record documented diagnoses in part: fracture part of neck of right femur, dislocation of internal right hip prosthesis, muscle weakness, chronic lymphocytic leukemia of b-cell type not having achieved remission, peripheral venous insufficiency, dementia mild with behavioral disturbance, pain, repeated falls, dizziness and giddiness, and anxiety. The Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 07. This indicated R14 had severe cognitive impairment. R14 had inattention and disorganized thinking. The MDS documented R14 had impairment to one side of the lower extremities. R14 is dependent for transfers, toileting hygiene, showering, oral care, lower body dressing, bed mobility and is incontinent of bowel and bladder. On 10/08/24 at 7:17 a.m., Surveyor observed R14 up and dressed in broda chair by nurse's station. Surveyor continually observed R14 sitting by the nurse's station. At 8:00 a.m., staff wheeled R14 to dining room for breakfast, and at 9:19 a.m. staff wheeled R14 back to nurse's station. Staff did not bring R14 to R14's room for incontinence care or ask if R14 needed to use the bathroom. R14 continued to be sitting in broda chair at the nurse's station until staff wheeled R14 to the dining room for lunch at noon. At 1:00 p.m., staff wheeled R14 from the dining room and placed R14 by the nurse's station. Staff did not bring R14 to R14's room for incontinence care or ask if R14 needed to use the bathroom. On 10/08/24 at 1:40 p.m., Surveyor interviewed Certified Nursing Assistant (CNA) J about when R14 was last toileted. CNA J indicated it was when R14 got up this morning. Surveyor asked when R14 would be toileted. CNA J indicated R14 would ask when R14 needed to go to the bathroom. On 10/09/24 at 12:32 p.m., Surveyor interviewed Interim Director of Nursing (DON)H about R14 being dependent on staff for toileting and when incontinence care is to be provided. Interim DON H indicated residents should be toileted before and after meals and staff will be educated.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40181 Based on observation, interview, and record review, the facility did not provide care consistent with professional standards to prevent development of a pressure injury (PI) for two of three residents (R) reviewed for pressure injuries (R29 and R18.) R29 was admitted to the facility with no skin impairments and developed a stage 3 pressure injury to the coccyx area (tailbone) which remains unhealed, due to lack of comprehensive assessments, lack of timely care plan interventions, and lack of repositioning. This example is being cited at actual harm. Facility did not complete comprehensive assessment on admission of R18's present PIs and did not implement care plan interventions timely or follow the repositioning schedule to prevent a stage 2 pressure injury from occurring. Findings include: According to the National Pressure Injury Advisory Panel (NPIAP) Prevention and Treatment of Pressure Ulcers/Injuries: Clinical Practice Guideline, 2019, Reposition all individuals with or at risk of pressure injuries on an individualized schedule, unless contraindicated. Determine repositioning frequency with consideration to the individual's level of activity and ability to independently reposition. Reposition the individual in such a way that optimal offloading of all bony prominences and maximum redistribution of pressure is achieved. According to the National Pressure Injury Advisory Panel (NPIAP) Prevention and Treatment of Pressure Ulcers/Injuries: Clinical Practice Guideline, 2019, A pressure injury is defined as localized damage to the skin and/or underlying tissue, as a result of pressure or pressure in combination with shear. Pressure injuries usually occur over a bony prominence but may also be related to a device or other object. Facility policy and procedure entitled Pressure Injury Prevention and Management, dated 08/02/24, states in part, .Assessments of pressure injuries will be performed by a licensed nurse, and documented. The staging of pressure injuries will be clearly identified to ensure correct coding on the MDS [Minimum Data Set] . R29 was admitted to the facility on [DATE] with the following diagnoses, in part, spina bifida (congenital disorder of the nervous system), morbid obesity, adult failure to thrive, changes in skin texture, history of diseases of the skin and subcutaneous tissue, and generalized muscle weakness. On 10/07/24 at 9:08 AM, Surveyor interviewed R29, who reported he had a sore on his bottom that the nurses are changing a bandage on daily. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R29's admission MDS assessment, dated 12/05/23, stated R29 was completely dependent on caregivers for all Activities of Daily Living (ADLs) and all mobility. The MDS assessment also identified R29 was at risk for the development of pressure injuries but had no current unhealed pressure injuries. Under the skin and ulcer treatment section of the MDS assessment, no was marked for pressure reducing device for chair, pressure reducing device for bed, turning/repositioning program, and nutrition or hydration program to manage skin problems. There were no refusals or rejection of cares documented on the MDS. R29's MDS assessment, dated 08/12/24, identified R29 had one stage 2 pressure injury and one stage 4 pressure injury. Under the skin and ulcer treatment section of the MDS assessment, no was marked for pressure reducing device for chair, pressure reducing device for bed, and turning/repositioning program. Yes was marked for nutrition or hydration program to manage skin problems. There were no refusals or rejection of cares documented on the MDS. R29 had a Braden risk assessment score of 12 on 11/29/23. This identified R29 was high risk for developing pressure injuries. R29's Braden score was 9 on 08/09/24, which indicated R29 was very high risk for developing pressure injuries. R29's baseline care plan, dated 11/28/23, had nothing checked under current or history of skin integrity issues. R29 had the following care plan: The resident has potential for pressure ulcer development r/t [related to] Immobility, incontinence, weakness, diagnoses/medications that can/may affect skin integrity. Coccyx. Date initiated: 12/06/23. Revision on: 10/07/24 Goal: The resident's Pressure ulcer will show signs of healing and remain free from infection by/through review date. Date initiated: 10/07/24 Interventions: Administer medications as ordered. Monitor/document for side effects and effectiveness. Date initiated: 12/06/23 Administer treatments as ordered and monitor for effectiveness. Date initiated: 12/06/23 APM [Alternating Pressure Mattress] on Bed to Alleviate Pressure. Date initiated: 10/07/24 Educate the resident/family/caregivers as to causes of skin breakdown; including: transfer/positioning requirements; importance of taking care during ambulating/mobility, good nutrition and frequent repositioning. Date initiated: 12/06/23 Follow facility policies/protocols for the prevention/treatment of skin breakdown. Date initiated: 12/06/23 Instruct and assist as needed to shift weight in W/C [wheelchair] q [every] 15 minutes. Date initiated: 12/06/23, revision on: 02/29/24 (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Monitor for s/sx [signs or symptoms] of infection: Redness, swelling, purulent drainage, warmth, tenderness or pain, Date initiated: 09/25/24 Monitor nutritional status. Serve diet as ordered, monitor intake and record. Date initiated: 12/06/23 Nutrition Supplements Liqua Cell for wound healing. Date initiated: 10/07/24 Patient goes to wound clinic. Date initiated: 09/25/24 Roho W/c [wheelchair] Cushion. Date initiated: 09/25/24 Teach resident/family the importance of changing positions for prevention of pressure ulcers. Encourage small frequent position changes. Date initiated: 12/06/23 The resident requires the bed as flat as possible to reduce shear. The resident prefers to be repositioned q4h per his request. Date initiated: 01/17/24 Surveyor identified a Weekly Summary-Skin Condition document, dated 02/07/24, that indicated R29 had no skin impairments. The only preventative measure currently in place was barrier cream, and R29 required the assist of two for repositioning. The Weekly Summary-Skin Condition document, dated 02/21/24, indicated R29 had no skin impairments. Preventative measures in place were turning/repositioning program, heels elevated when in bed, and barrier cream. The Weekly Summary-Skin Condition document, dated 03/13/24, indicated R29 had open lesions to the back of knees from sling. The only preventative measure currently in place was barrier cream, and R29 required assist of two for repositioning. There was a communication sent to the provider updating about the open areas. R29's skin integrity care plan was not updated. A physician's orders sheet from a Nurse Practitioner (NP), dated 03/21/24, identified R29 had unstageable pressure injuries to both lateral knees. The order sheet included Pad wheelchair sides where knees meet w/c to offload pressure. PT [physical therapy] involved to reduce pressure areas. R29's skin integrity care plan was not updated. The Weekly Summary-Skin Condition document, dated 03/22/24, identified R29 had pressure injuries to right and left lateral knees. Skin preventative measures checked included: special pressure relieving mattress, pressure relieving cushion in chair, pillows for repositioning, and barrier cream. R29's skin integrity care plan or treatment orders were not updated to reflect these interventions. There is no further documentation of assessments with description or measurements of the pressure injuries until 04/04/24. A Skin Only Evaluation document, dated 04/04/24, identified R29 had a newly identified stage 3 pressure injury to the coccyx measuring 2 centimeters (cm) long by 2 cm wide by 0.5 cm deep. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The wound had undermining of 0.5 cm at 5 to 7 o'clock. There was a physician's order sheet dated 04/04/24 from the NP with orders for treatment of the new pressure injury to the coccyx. The orders also included: Dietician eval and treat for diet to enhance wound healing yet decrease caloric intake. There is no documentation of an evaluation by a dietician until 06/11/24. R29's skin integrity and nutrition care plans were not updated to reflect interventions for the new pressure injury to the coccyx to promote wound healing and prevent further breakdown. There was no documentation of assessments of R29's pressure injuries with staging, description of wounds, or measurements between 04/05/24 to 04/26/24. The next documentation of assessment of R29's pressure injuries was dated 04/26/24. The documentation identified the coccyx wound as a stage 4 pressure injury with measurements of 3 cm long by 3 cm wide by 3 cm deep. The documentation indicated the wound had tunneling and undermining 1 cm around 1 o'clock and 2 cm at 7 o'clock. It is of note that on 10/09/24 at 1:18 PM, Surveyor interviewed Registered Nurse (RN) C, who was the first nurse to document that R29's coccyx wound was a stage 4 pressure injury on 04/26/24. Surveyor asked RN C what they based that assessment on. RN C stated they labeled R29's coccyx wound stage 4 based on assessment by a wound care NP who made wound rounds in the facility on that date. RN C searched the medical record and found a handwritten order from the NP that documented Coccyx ulcer stage III . RN C stated they were in error and mistakenly documented R29's coccyx wound a stage 4. All weekly wound documentation between 04/26/24 through 09/13/24 labeled the coccyx wound stage 4. There was weekly documentation of assessment of the wounds with description and measurements that were essentially unchanged from 04/26/24 through 06/07/24. Surveyor identified a nutritional assessment completed by the dietician dated 06/11/24. The note identified R29 had several wounds and made recommendations for increasing a liquid protein supplement to three times per day and adding liquacel protein supplement twice per day. R29's skin and nutrition care plans were not updated to reflect these recommendations. The weekly wound documentation on 06/14/24 identified R29's coccyx wound had increased in size to 4 cm by 4 cm by 2.5 cm with undermining. There was weekly documentation with assessments and measurements of wounds that were essentially unchanged from 06/14/24 through 07/05/24. There was no documentation of wound assessments between 07/05/24 and 07/19/24. The weekly wound assessment documentation of R29's coccyx wound from 07/19/24 through 09/13/24 was essentially unchanged. All other pressure injuries were resolved by 09/13/24. Beginning 09/18/24, the facility began using a new system for documenting wounds and all weekly wound documentation and summaries were complete on the medical record from that date. The coccyx wound from that date going forward was staged as a stage 3 pressure injury. On 10/07/24, Surveyor observed R29 seated in wheelchair from 10:45 AM through 4:00 PM. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 10/08/24 at 10:26 AM, Surveyor observed RN C provide wound care for R29's coccyx wound. No concerns were identified with infection control or wound care procedure. The wound was observed to be a deep crater in the center of coccyx area. The wound bed appeared clean with minimal slough and no signs of infection. RN C stated Interim Director of Nursing (IDON) H would do wound care tomorrow with a full assessment of the wound with measurements. On 10/08/24, Surveyor observed R29 seated in wheelchair from 10:45 AM through 4:00 PM. On 10/09/24 at 9:33 AM, Surveyor interviewed Certified Nursing Assistant (CNA) D and asked if they did any special turning or repositioning for R29. CNA D stated when R29 was in bed they offered to turn R29 about every 4 hours, but R29 spent most days up in the wheelchair all day from the time they got R29 up which was mid-morning today. On 10/09/24 at 10:42 AM, Surveyor interviewed IDON H who took over as interim DON in July. IDON H stated a different nurse was managing wound care at that time. IDON stated they did not discover there was a problem with wound assessments and documentation until September. Surveyor reviewed the documentation of R29's wound care described previously with IDON H. IDON H agreed the facility staff did not care for or document R29's wound appropriately to prevent development of pressure injuries and promote healing. 48793 Example 2: R18 was admitted to the facility on [DATE] with diagnoses including in part, vascular dementia, hemiplegia and hemiparesis cerebral infarction, dysphagia, osteomyelitis left elbow, pressure ulcer stage 4 left elbow, type 2 diabetes mellitus, heart failure, and benign prostatic hyperplasia with lower urinary tract infections. R18 was admitted with 3 PIs and facility did not identify location, sizes, or stages and is unclear determining the condition of the pressure injuries at admission. R18's Minimum Data Set (MDS) assessment, dated 01/11/24, identified on admission that R18 had a Brief Interview for Mental Status (BIMS) score of 08. This indicated R18 had moderate cognitive impairment. The MDS assessment also identified R18 required total dependent assistance of two people for bed mobility, taking on and off footwear, rolling left to right, sit to lying, chair to bed, toileting, eating, and for transfers. MDS also indicated that R18 was determined to be at risk for PIs and currently had one stage 4 PI. Surveyor reviewed R18's right gluteal and left buttock pressure injury care plan initiated on 04/25/24 and revised 10/07/24, in part: -Educate and encourage good nutrition and hydration in order to promote skin integrity initiated on 04/25/24. -Observe/identify/document potential causative factors for alterations in skin integrity. Eliminate/resolve where possible initiated on 04/25/24. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Reposition resident every 1-2 hours initiated on 04/25/24. -Wound dressing treatments per provider initiated on 04/25/24 and revised on 10/07/24. -Roho cushion in wheelchair initiated on 09/25/24. -APM for pressure reduction and prevent sheering initiated on 09/25/24. -Monitor for signs and symptoms of infection: increased warmth, redness, swelling, purulent drainage, pain or tenderness initiated on 09/25/24. -Nutrition supplement three times a day to promote wound healing initiated on 09/25/24. -Resident will not develop any further skin breakdown, redness, blisters, or discoloration initiated on 10/07/24. Surveyor reviewed R18's physician orders, which state in part: -On 02/08/24: position resident on his side for 1 hour post meals three times a day. -On 04/04/24: . MEASURE EACH WOUND WIDTH, LENGTH, DEPTH, AND DOCUMENT WOUND DESCRIPTION (DRAINAGE, COLOR, ODOR, ETC.), tunneling, and what wound care was provided. -On 09/05/24: Check inflation of high low ROHO cushion every day and adjust as necessary to limit pressure while up in w/c or recliner every morning and at bedtime for Pressure Ulcer. Two times a day for wound prevention. - On 09/25/24: Check Alternating Air Mattress for proper functioning every shift. Surveyor reviewed Braden score assessment dated [DATE] incomplete. Surveyor did not find R18's score to determine the risk of PIs and skin breakdown. Surveyor reviewed admission nurse progress notes, which state in part: -On 01/04/24, R18 has Deep tissue injury to the left elbow, stage 4, 2x1x1.2cm, open lesions in 4 places on left buttock. No thorough assessment including documentation of location of PI, PI measurements, or description of condition of PIs noted on admission. -On 01/27/24, R18 has left buttock open lesion 4cmx2cm, left buttock open lesion 3.5cmx2cm, left buttock open lesion 3cmx1cm, left buttock open lesion 6cmx3cm, left elbow pressure injury 2.5cmx1x0.5cm. The open areas on the buttocks are not called PIs, or staged. R18 was hospitalized [DATE] and returned on 1/29/24. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-On 01/29/24, nurses note in part, R18 has left buttock open lesion 6cmx3cm left buttock open lesion 3. 5cmx2cm, left buttock open lesion 3cmx1cm, left buttock open lesion 6cmx3cm, left elbow pressure injury stage 4 2.5cmx1x0.5cm. No new interventions were put into place for R18's pressure injuries. -On 02/15/24, R18's left buttock is assessed as stage 2 PI 1.7x1.1x0.1cm, left buttock is assessed as stage 2 PI 1x0.5x0.1cm, right buttock is assessed as stage 2 PI 3.5x2x0.1cm, new right buttock stage 2 PI 0.6X0. 6cm., right posterior thigh PI stage 3, 4x1x0.2cm. Facility did not identify exact locations on left and right buttocks and is unclear determining the condition of the pressure injuries. No new interventions were put into place for R18's pressure injuries. -On 05/09/24, R18's Right posterior thigh PI stage II, 1x0.3cm. New right posterior thigh PI at stage 2 measures 3x5cm. This contradicts documentation in note on 2/15/24. Surveyor interviewed Interim DON H about this entry. Interim DON H stated they were stage 2 on admission, just not clearly documented. Facility did not identify wounds by numbers and is unclear determining the condition of the pressure injuries. No new interventions were put into place for R18's pressure injuries. -On 10/09/24, R18 has PI noted to the right gluteal fold buttock measures 0.3x1.1x0.1cm. Provider will be updated of new area assessed. Observations: On 10/07/24 at 9:28 AM, Surveyor observed R18 lying in bed. R18 appeared to be sleeping, but Surveyor observed R18 to have contracted hands bilaterally. Surveyor observed R18's bed positioned high and R18 lying supine on back in bed. On 10/07/24 at 9:56 AM, Surveyor observed R18 yelling for assistance from R18's room. On 10/07/24 10:07 AM, Surveyor observed Certified Nurse Assistant (CNA) F enter R18's room. R18 indicated R18 was cold and needed a blanket. CNA F gave R18 a blanket and exited R18's room. Surveyor observed R18 lying supine on back in bed. On 10/07/24 at 10:20 AM, Surveyor observed R18 yelling for assistance from R18's room. On 10/07/24 at 10:23 AM, Surveyor observed CNA D enter R18's room and ask R18 what R18 needed. R18 stated that R18 wants to get up out of bed. CNA D indicated to R18 that staff just laid R18 down in bed and would get R18 up before lunch. Surveyor observed R18 lying supine on back in bed. On 10/07/24 at 11:35 AM, Surveyor observed CNA D and CNA J transfer R18 via Hoyer lift to wheelchair. (continued on next page)

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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Surveyor did not observe R18 repositioned on side post meal for an hour or repositioned every 1-2 hours as the care plan instructs. Observations on 10/08/24: On 10/08/24 at 6:48 AM, Surveyor observed R18 sitting in wheelchair in dining room. On 10/08/24 at 8:00 AM, Surveyor observed R18 sitting in wheelchair in dining room. Surveyor did not observe R18 repositioned as ordered. On 10/08/24 at 9:05 AM, Surveyor observed R18 in wheelchair in room with call light attached. R18 utilized call light for assistance. CNA D entered and asked R18 what was needed. R18 indicated that R18 wanted to lie down in bed. CNA D exited R18's room. Surveyor did not observe R18 repositioned as ordered. On 10/08/24 at 9:08 AM, Surveyor observed CNA J and CNA D enter R18's room to transfer with Hoyer. On 10/08/24 at 9:18 AM, Surveyor observed R18 on back lying in bed. Surveyor did not observe R18 repositioned on side post meal for an hour as ordered. On 10/08/24 at 9:39 AM, Surveyor interviewed LPN G and RN C about R18's wound dressing changes. RN C indicated that LPN G would be doing wound rounds with Interim DON H tomorrow on Wednesdays. RN C indicated that R18's wounds are on both buttocks and left side opened is a stage 2. On 10/08/24 at 10:26 AM, Surveyor observed CNA J and CNA D enter R18's room and reposition R18 to right side slightly with pillow under left side. On 10/08/24 at 1:23 PM, Surveyor observed R18 lying in bed on back. R18's wife in visiting R18. Surveyor did not observe R18 repositioned on side post meal for an hour as ordered. On 10/08/24 at 2:12 PM, Surveyor observed R18 lying in bed on back. Surveyor did not observe R18 repositioned on side post meal for an hour as ordered. On 10/08/24 at 2:43 PM, Surveyor observed R18 lying in bed on back. Surveyor did not observe R18 repositioned every 1-2 hours as ordered. On 10/08/24 at 3:04 PM, Surveyor observed R18 lying in bed on back. Surveyor did not observe R18 repositioned every 1-2 hours as ordered. On 10/08/24 at 3:33 PM, Surveyor observed R18 lying in bed on back. Surveyor did not observe R18 repositioned every 1-2 hours as ordered. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 10/09/24 at 7:02 AM, Surveyor observed Interim DON H perform wound dressing change on R18. Interim DON H indicated through assessment and wound cleaning, R18 has a stage 2 PI, 1.6x1x1.0 cm of the left gluteal inferior area. On 10/09/24 at 10:20 AM, Surveyor interviewed CNA D and asked about repositioning R18. CNA D indicated that R18 is repositioned every 2 hours and as needed. Surveyor asked CNA D if R18 was repositioned every 2 hours for the past 3 days. CNA D indicated that R18 should be repositioned every two hours and has an air mattress in place. Surveyor asked CNA D if CNA D follows physician orders that indicates R18 should be repositioned onto side post meals for an hour three times a day. CNA D indicated that CNA D is unaware of this order and that staff make sure R18 is repositioned every 2 hours from side to side. On 10/09/24 at 10:24 AM, Surveyor interviewed Interim DON H and asked about repositioning R18. Interim DON H indicated that R18 is to be repositioned every 1-2 hours. Surveyor indicated to Interim DON H that R18 was not repositioned every 2 hours for the past 3 days. Surveyor did not observe R18 positioned off back and buttocks but twice in the last 3 days. Interim DON H indicated that R18 should be repositioned every 1-2 hours. Interim DON H indicated to Surveyor the physician order for repositioning on side for one hour post meals is a dumb order but will update care plan after verifying order is correct. On 10/08/24 at 3:09 PM, Surveyor interviewed Interim DON H and asked about wound documentation for R18. Interim DON H indicated that wound documentation has not been being recorded accurately and is in 4-5 different skin assessment sections throughout the electronic health record. Surveyor asked Interim DON H if R18 had pressure injuries on admission. Interim DON H was not here at that time. Interim DON H indicated that Interim DON H could not specify if R18's right posterior thigh was from admission or acquired in facility. Surveyor asked Interim DON H to clarify open areas. Interim DON H stated, [R18] has pressure injuries on buttocks that is being staged at a 2 and wound rounds weekly. Interim DON H indicated that once Interim DON H observed that wound care was not going the best, Interim DON H started a full facility skin sweep and implemented a PIP in September.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48793 Based on observation, interview and record review, the facility did not ensure residents with limited range of motion receive appropriate treatment and services to maintain or increase range of motion. This occurred for 1 of 2 residents (R) R17, who were reviewed for range of motion services. R8 has a left arm and left leg weakness following a stroke effecting non-dominant side. The resident's range of motion program was never started. This is evidenced by: R17 was admitted to the facility on [DATE] with diagnoses including in part, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, dysphagia, atherosclerotic heart disease, essential hypertension, and osteoarthritis of left knee. R17's Minimum Data Set (MDS) assessment, dated 02/02/24, identified that R17 had a Brief Interview for Mental Status (BIMS) score of 12. This indicated R17 had moderate cognitive impairment. The MDS assessment also identified R17 required substantial/maximal assistance with bed mobility, rolling left to right, sit to lying, chair to bed, taking on and off footwear, toileting, and for transfers. R17's Minimum Data Set (MDS) assessment, dated 08/17/24, identified R17 required total dependent assistance of two people for bed mobility, taking on and off footwear, rolling left to right, sit to lying, chair to bed, toileting, and for transfers. Surveyor reviewed MDS documentation from 02/02/24 to 08/17/24 which identified R17 to have a decline in mobility and ADL functions. Surveyor reviewed R17's care plans. Surveyor did not find a restorative care plan in place. Surveyor reviewed R17's Physical Therapy (PT) notes, which state in part: On 03/17/24, PT recommends discharging R17 from PT and continuing with a restorative range of motion program for R17's left upper arm and left lower extremity. On 10/07/24 at 9:08 AM, Surveyor interviewed R17. R17 indicated that R17 had a stroke and now has left arm and left leg weakness from stroke. R17 indicated that R17 uses a Hoyer lift to transfer. R17 indicated that R17 feels R17 has not received appropriate services to maintain some independence and now R17 is totally reliant on staff for all cares. Surveyor observed cares and there was no restorative care provided to R17 during the 3 day survey. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/09/24 12:11 PM, Surveyor interviewed Certified Nurse Assistant (CNA) F and asked about restorative range of motion program in place for R17. CNA F indicated there is no restorative aide in place at this time and that all CNAs should be completing range of motion with residents that are in the restorative book located at nurse's station. Surveyor asked how the decision is made for residents to be placed in the restorative book. CNA F indicated the order comes from Physical Therapy (PT) and then it is placed in the restorative book, so all staff know to complete restorative program or correct interventions per the individualized goals. Surveyor asked if R17 is on a restorative program. CNA F indicated R17 is not in the restorative book for a restorative range of motion program at this time. On 10/09/24 at 12:17 PM, Surveyor interviewed Occupational Therapist (OT) L and asked about restorative program in place for R17. OT L indicated that R17 was discharged from PT at end of March 2024 with a restorative program to be utilized to maintain functionality in lower extremities. OT L indicated that R17 was discharged from OT at end of March as well with a restorative range of motion program for upper left extremity. On 10/09/24 at 12:22 PM, Surveyor observed restorative program book located at nurse's station. Surveyor did not find a restorative program in place for R17 to inform CNAs that restorative range of motion program for left upper extremity and lower extremities need to be completed. On 10/09/24 at 12:34 PM, Surveyor interviewed CNA E and asked about a restorative range of motion program in place for R17. CNA E indicated CNA E is unaware of a restorative program in place for R17. Surveyor asked CNA E if CNA E completed restorative exercises for R17. CNA E indicated CNA E did not complete exercises for R17. On 10/09/24 at 12:46 PM, Surveyor interviewed Interim Director of Nursing (DON) H and asked about restorative program for R17. Interim DON H indicated Interim DON H was unaware of a restorative program ordered in March for R17. Surveyor indicated to Interim DON H that Surveyor did not observe restorative exercises offered or completed for R17. Interim DON H indicated Interim DON H's expectation would be if PT/OT recommended restorative range of motion program then staff should have completed the restorative program with R17 at some point every day.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49353 Based on observation, record review and interview, the facility did not ensure drugs and biologicals used in the facility are labeled in accordance with current accepted professional principles for 1 of 2 insulin pen medications reviewed during medication administration observation. This had the potential for harm to affect resident (R)2. This is evidenced by: Current Wisconsin State pharmacy labeling requirements effective December 2020 state all prescription medications must include in part: .patient name, date of birth, name and strength of medication, dosage, route . R2 was admitted to facility on 04/30/20 with a pertinent diagnosis of diabetes mellitus II. R2 has a prescription order for Admelog SoloStar Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Lispro) Inject as per sliding scale: if 140 - 179 = 4; 180 - 219 = 6; 220 - 259 = 8; 260 - 299 = 10; 300 - 339 = 12; 340 - 379 = 14; 380 - 399 = 15 greater than 399 call MD, subcutaneously two times a day for Diabetes my interchange lispro and aspart Hold if resident ref meal BS Parameters below 60 or above 400 call MD On 10/08/24 at 11:40 AM, Surveyor observed Registered Nurse (RN) C complete medication administration of insulin to R2. Surveyor observed R2's insulin lispro injection pen had a pharmacy label stating name, dispensed date of 09/20/24, open date of 09/29/24, and dose to be administered of 7 units subcutaneously before lunch. Surveyor reviewed physician order and Medication Administration Record (MAR) in R2's Electronic Medical Record (EMR) and noted as being to administer per sliding scale. Surveyor asked RN C to verify this finding. RN C verified the current order was to administer sliding scale dose based on blood sugar result. Surveyor asked RN C why the medication label from pharmacy on the insulin pen did not match the order. RN C stated the order was changed a while ago, but the pharmacy keeps sending the new insulin pens with the wrong label. Surveyor asked RN C what the expectation would be when finding a medication label does not match the order. RN C stated to notify the pharmacy and verify the order listed in the resident's EMR. On 10/09/24 at 1:44 PM, Surveyor interviewed Director of Nursing (DON) B regarding the facility policy of medication labeling. DON B stated the expectation for verifying medication labels would be completed when medication was received from pharmacy and when staff are administering the medication during verification of right resident, medication, dose, route, and frequency. DON B stated that if an error is observed, then the nurse would apply a sticker to the medication to verify order with the Medication Administration Record (MAR) prior to administration. Surveyor explained the finding of the incorrect dosage on the medication label and no label was attached to verify order prior to administration. DON B stated this should have been corrected when the insulin pen was first received on 09/20/24 and acknowledged the error had the potential to harm R2. No evidence was provided that the pharmacy had been notified of this error or was corrected.

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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 40181

Based on observation, interview and record review, the facility did not maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections. Staff did not perform hand hygiene with glove changes during morning cares and catheter cares for 2 of 4 residents (R). (R2 and for R29)

Findings include:

Facility policy and procedure entitled, Hand Hygiene, dated 02/02/24, states in part, .The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves .

Example 1

R2 was admitted to the facility on [DATE] with diagnoses including, in part, type 2 diabetes, renal failure and neurogenic bladder.

On 10/07/24 at 11:48 AM, Surveyor observed a sign on the outside of R2's room that stated enhanced barrier precautions (EBP). Record review identified R2 was on EBP due to an indwelling Foley catheter.

On 10/08/24 at 8:14 AM, Surveyor observed Certified Nursing Assistants (CNAs) D and E provide morning cares and catheter cares for R2. CNA D used hand sanitizer, put on a gown and gloves, and pushed a mechanical lift into R2's room. CNA D got supplies ready and adjusted R2's bed. CNA D removed gloves, washed hands at the sink, put on clean gloves, and carried a wet washcloth to R2's bed and washed R2's face. CNA E entered the room with a gown on, washed hands at the sink and put on gloves. CNA E removed R2's socks, inspected the skin on R2's feet, put Tubi grips on each leg, and put socks back on. CNA D carried the washcloth to the sink, removed gloves, and put on clean gloves without using hand sanitizer or washing hands. CNA D carried a wet washcloth to R2's bed and washed around the Foley catheter from insertion around tip of penis, down penis, and down catheter tubing. CNA D rinsed and dried in the same order. CNA D carried the washcloths to the sink, removed gloves and put on clean gloves without washing hands or using hand sanitizer. CNA E assisted R2 to roll to the side. CNA D used wet wipes from a package to wash R2's back side. CNA D removed the soiled brief and threw the brief, wipes, and gloves in the trash. CNA D put on clean gloves without using hand sanitizer or washing hands. CNA D put barrier cream on R2's bottom. CNA D removed gloves and put on clean gloves without using hand sanitizer or washing hands. CNA D put a clean brief on R2 and both CNAs assisted R2 to roll on back. Both CNAs fastened the brief. Both CNAs put R2's pants on R2's legs and CNA D fed the catheter bag through leg of the pants. Both CNAs put shoes on R2 and assisted R2 to sit up on the edge of the bed. CNA E removed R2's shirt. CNA D removed gloves and put on clean gloves without using hand sanitizer. CNA D used a wet washcloth to wash R2's upper body, back, and under arms. Both CNAs put a clean shirt and jacket on R2. Both CNAs transferred R2 from bed to wheelchair using the mechanical lift. After cleaning up supplies and linens, both CNAs removed gowns and gloves and used hand sanitizer before leaving R2's room.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Example 2 On 10/07/24 at 8:45 AM, Surveyor observed a sign on the outside of R29's room that said EBP. On 10/08/24 at 10:26 AM, Surveyor observed CNAs D and E provide morning cares for R29. Both CNAs used hand sanitizer and put on gowns and gloves before entering the room. CNA E used a washcloth to wash R29's perineal area from the front. After washing, rinsing, and drying the area, CNA E removed the gloves and put on clean gloves without using hand sanitizer or washing hands. CNA E then continued to assist with cares. After assisting R29 to wash up R29, CNA E took the wash basins to the sink and emptied them. CNA E removed the gloves and put on clean gloves without using hand sanitizer or washing hands. CNA E continued assisting R29 with morning cares and repositioning R29 during wound care provided by the nurse. On 10/09/24 at 10:38 AM, Surveyor interviewed Interim Director of Nursing (IDON) H and informed of observations of CNAs not performing hand hygiene between glove changes during cares for R2 and R29. IDON H stated all staff should either wash hands or use hand sanitizer when changing gloves during cares or procedures. IDON H stated the CNAs did not follow good infection control practices or the facility policy.