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

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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 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. Based on interview and record review, the facility did not complete a performance review of every nurse aide at least every 12 months and provide 12 hours of regular in-service education based on the outcome of for 6 of 6 CNAs reviewed. This has the potential to affect all 47 residents.This is evidenced by:On 01/06/26, a sample of CNAs employed by the facility was selected for review for the completion of annual performance reviews. The facility provided the following information:CNA D has a hire date of 06/10/24. The annual performance review is dated 06/19/25. No documentation of in-service education based on performance review is noted.CNA K has a hire date of 04/24/24. The annual performance review is dated 08/12/25. No documentation of in-service education based on performance review is noted.CNA L has a hire date of 10/22/21. The annual performance review is dated 11/06/25. No documentation of in-service education based on performance review is noted.CNA M has a hire date of 04/15/24. The annual performance review is dated 08/12/25. No documentation of in-service education based on performance review is noted.CNA N has a hire date of 04/12/23. The annual performance review is dated 08/12/25. No documentation of in-service education based on performance review is noted.CNA O has a hire date of 09/20/21. The annual performance review is dated 11/06/25. No documentation of in-service education based on performance review is noted.On 01/06/26 at 3:12 PM, Surveyor interviewed Director of Nursing (DON) B regarding performance reviews and in-service education. DON B stated she did not have any documentation for training because it hadn't been done. DON B stated that she is aware this is a concern and will be working on this. Surveyor asked DON B if the facility had a Performance Improvement Plan in place to resolve this issue. DON B stated no.

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

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

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interview and record review, the facility did not complete the required annual 12 hours of in-service training for nurse aides for 6 of 6 CNAs reviewed. This has the potential to affect all 47 residents.This is evidenced by:On 01/06/26, a sample of CNAs employed by the facility was selected for review for 12 hours of in-service training. The facility provided the following documentation:CNA D has a hire date of 06/10/24. No documentation of required annual 12 hours of in-service training.CNA K has a hire date of 04/24/24. No documentation of required annual 12 hours of in-service training.CNA L has a hire date of 10/22/21. No documentation of required annual 12 hours of in-service training.CNA M has a hire date of 04/15/24. No documentation of required annual 12 hours of in-service training.CNA N has a hire date of 04/12/23. No documentation of required annual 12 hours of in-service training.CNA O has a hire date of 09/20/21. No documentation of required annual 12 hours of in-service training.On 01/06/26 at 3:12 PM, Surveyor interviewed Director of Nursing (DON) B regarding required annual in-service training. DON B stated that this has not been completed for any CNAs other than random nursing care topics discussed at monthly staff meetings. Surveyor asked DON B if she was aware of this annual requirement. DON B stated yes and the facility was working on fixing it. Surveyor asked for documentation of completed dementia training as a high percentage of the facility residents have dementia. DON B provided Surveyor with education that was last completed on 09/26/24. Surveyor asked DON B if she was aware this needed to be completed annually. DON B stated yes that this is being worked on. Surveyor asked DON B if there was a Performance Improvement Plan in place documenting their plan to fix this issue. DON B stated no.

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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 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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: 08/27/2025 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 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CNA doing 1:1 supervision every shift. Document EVERY SHIFT on resident's mood and behavior. Note any 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 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's policy titled, Falls Management, read in part, Add to temporary plan of care-include 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)

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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.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview and record review, the facility did not provide a safe and sanitary environment to help prevent the development and transmission of communicable diseases and infections.-The facility did not ensure proper hand hygiene during water pass for 4 of 4 residents observed (R35, R18, R46, & R16).-The facility did not ensure appropriate personal protective equipment (PPE) was donned during wound care for 1 of 1 resident observed (R34).-The facility did not ensure appropriate PPE was donned while administering eye drops to 1 of 1 resident observed (R21).Findings include: Facility Policy titled, Infection Prevention and Control Manual, dated 2023, reads in part: Personal Protective Equipment (PPE) required for contact precautions includes a gown and gloves when entering the room. The facility's nursing education sheet, dated 8/7/25, states in part, Infection Control- .Hand sanitizer is be used as entering, leaving (R's room) . On 1/5/26 at approximately 1:00 PM, Surveyor observed Certified Nursing Assistant (CNA) N exit R35's room carrying an almost empty water cup by the handle with her bare hands. CNA N set it on lower shelf of cart, grabbed a new water cup from top of the cart and proceeded in R18's room without practicing hand hygiene. Surveyor heard CNA N telling R18 she was bringing her fresh water and asked to take used water cup. Surveyor observed CNA N come out of R18's room with used water cup, place it on bottom shelf of the cart and grab another clean water cup from top of cart and proceeded into R16's room, returned with an empty cup and placed on the cart. CNA N again, did not practice hand hygiene before taking a clean water cup into R46's room and returning with used water cup. Surveyor immediately interviewed CNA N, who stated hand hygiene was done after completing that hall. CNA N stated her hands get cracked from hand sanitizer and she was unaware that she should use after touching contaminated surfaces such as residents' used water cups. On 1/7/26 at approximately 12:00 PM, Surveyor observed wound care provided for R34. Surveyor noted Registered Nurse (RN) W did not wear a gown and assisted provider with R34's wound care. R34's sign outside her door indicated contact precautions. RN W participated in R34's wound care by gathering supplies, applying skin prep and dressings to R34's open skin areas. On 1/7/26 at 12:25 PM, Surveyor interviewed RN W, who stated she didn't wear a gown when performing wound care for R34 because she wasn't at risk for splashing. Surveyor interviewed Director of Nursing (DON) B who was also present and stated that it was DON B's misunderstanding as DON B had told RN W a gown was only needed if there was a risk for splashing. Surveyor did review the CDC signage on R34's door, which indicated contact precautions, with DON B. DON B verbalized R34's signage should have been changed to Enhanced Barrier Precautions and states an understanding that gown should be worn with wound care with either of the two precautions for R34. DON B also verbalized agreement that hand hygiene needs to be performed when exiting a resident's room, after contact with resident's items, and prior to entering another resident's room. Findings include: Facility Policy titled, Personal Protective Equipment (PPE) dated 2023, reads in part: Gloves are worn when contact with blood or other potentially infections materials, mucous membranes, or contact with non-intact skin is anticipated .Contact precautions are intended to prevent transmission of pathogens (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	that are spread by direct or indirect contact with the resident or environment .and requires the use of appropriate PPE, including a gown and gloves before or upon entering the room. On 01/06/26 at 7:22 AM, Surveyor observed Licensed Practical Nurse (LPN) F administer medications to R21. LPN F administered 1 drop of artificial tears to each of R21's eyes. LPN F was not wearing gloves during administration. On 01/07/26 at 12:44 PM, Surveyor interviewed LPN G. LPN G stated that it would be appropriate to wear gloves when feeding a resident medication when your hand may touch the resident's mouth. LPN G stated it would be appropriate to wear gloves when administering patches, eye drops, and insulin. On 01/07/26 at 12:50 PM, Surveyor interviewed Registered Nurse (RN) H. RN H stated gloves would be appropriate when administering eye drops, creams, and patches. On 01/07/26 at 2:00 PM, Surveyor interviewed Director of Nursing (DON) B. DON B stated DON B's expectation for wearing gloves during med pass would include anything potentially hazardous, when administering eye drops, cleaning nebulizers, any time something is inserted, and when administering creams and ointments.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility must ensure each resident is free from unnecessary drugs as evidenced by completing adequate drug monitoring for 2 of 5 residents (R5 and R7) reviewed for unnecessary medication reviews.-The facility is not accurately monitoring resident-specific targeted behaviors for R7's psychotropic medication use. -The facility is not accurately monitoring resident-specific targeted behaviors for R5's psychotropic medication use. The facility policy titled, Psychotropic Medication, read in part, 4. Nursing will document daily on behaviors treated by antipsychotics/antianxiety/hypnotic. 8. PRN psychotropics and anti-anxiety medications will have behaviors to watch for and interventions to use prior to administration of medication. All behaviors and interventions used are to be documented. Example 1 R7 was admitted to the facility on [DATE]. Diagnoses included dementia with behavioral disturbance, depression, and anxiety. R7's Power of Attorney (POA) was activated to assist with decision making. R7's Minimum Data Set (MDS) assessment, completed on 12/08/25, confirmed R7 scored 04/15 during Brief Interview for Mental Status (BIMS), indicating severely impaired cognition. R7's MDS assessment revealed R7 exhibited physical, verbal, and wandering behaviors. R7's care plan included: -Resident has a diagnosis of anxiety, target behavior: pacing, 12/18/25. -Potential to demonstrate verbally and physically abusive behaviors related to dementia: analyze key times, places, circumstances, triggers, and what de-escalates behaviors and document. Document behavior and attempted interventions in behavior log, 10/07/25. -Diagnosis of depression and potential for decline in mood. Resident is prescribed an anti-depressant, 10/07/25. -Resident is at risk for elopement related to history of wandering and exit seeking behaviors, 08/27/25. R7's physician orders included the following psychotropic medications: -09/13/25-09/15/25, olanzapine 5 mg every 12 hours for agitation. -09/16/25-10/07/25, escitalopram 5 mg daily for depression. -10/08/25-12/17/25, fluoxetine 20 mg daily for depression. -10/21/25-11/04/25, olanzapine 5 mg two times daily for dementia with agitation. -11/15/25-11/20/25, Rexulti 0.5 mg at bedtime for anxiety. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-11/20/25-12/17/25, Rexulti 1 mg at bedtime for anxiety. -12/17/25-12/20/25, Rexulti 0.5 mg at bedtime for anxiety. -12/20/25-12/22/25, Rexulti 0.25 mg at bedtime for anxiety. -12/20/25-current, Depakote Sprinkles 125 mg, twice daily for dementia related agitation. -12/24/25-current, Celexa 10 mg daily for anxiety. R7's Treatment Administration Record (TAR) included: -Monitor anti-anxiety target behaviors: Document corresponding number that reflects the behavior presented: 0-None, 1-Hitting, 2-Kicking, 3-Pushing, 4-Scratching, 5-Grabbing, 6-Threatening, 7-Screaming, 8-Cursing, 9-Rummaging, 10-Pacing, 11-Restlessness, 12-Fidgeting, 13-Other, see nurse's note. Every shift. -Monitor Antidepressant target behaviors: Document corresponding number that reflects the behavior presented: 0-None, 1-Negative statements, 2-Decreased interaction with others, 3-withdrawl from activities, 4-Poor sleep, 5-crying, 6-sad effect, 7-change in eating habits, 8-self isolation, 9-Other-see nurses note. Surveyor reviewed R7's October TAR and noted: -Monitor antianxiety target behaviors. A check mark was placed daily for each shift. The TAR did not reflect corresponding number reflecting the behaviors presented. -Monitor antidepressant target behaviors. October 2025, all days marked 0 except for 10/26/25 and 10/31/25 marked with a 1-(negative statements). Surveyor reviewed R7's October progress notes and noted: -10/04/25, took the fire extinguisher and used it on the door, setting off the smoke alarm. -10/05/25, eloped from the facility. -10/07/25, swearing. -10/08/25, crying. -10/14/25, set off fire alarm. Swinging gait belt and hitting CNA. Police were called. -10/15/25, wandering. -10/16/25, exit seeking most of the day. -10/26/25, shouting. -10/30/25, verbal aggression towards staff. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-10/31/25, verbal aggression towards staff, swearing, statements of elopement. Surveyor reviewed R7's November TAR and noted: -Monitor antianxiety target behaviors, A check mark was placed daily for each shift. The TAR did not reflect corresponding number reflecting the behaviors presented. -Monitor antidepressant target behaviors. All days marked 0 except for 11/02/25, marked with 9-other. Surveyor reviewed R7's November progress notes and noted: -11/02/25, there were no behaviors documented in progress notes. -11/03/25, yelling, swearing, verbally aggressive towards staff, attempts at physical aggression towards staff, attempts to elope, awake most of the night. -11/08/25, yelling. -11/18/25, swearing. -11/22/25, nurse noted resident will spit out medications if taking whole. -11/27/25, wandering. One outburst. -11/28/25, a lot of behaviors. Yelling at staff. Surveyor reviewed R7's December TAR and noted: -Monitor antianxiety target behaviors. A check mark was placed daily for each shift. The TAR did not reflect corresponding number reflecting the behaviors presented. -Monitor antidepressant target behaviors. All days marked 0 except 12/28/25 and 12/29/25. Surveyor reviewed R7's December progress notes and noted: -12/01/25, physically aggressive with staff, punching CNA. -12/04/25, wandering. -12/08/25, yelling and swearing. -12/10/25, crying and yelling. -There were no behaviors documented in progress notes on 12/28/25 or 12/29/25. On 01/05/26 at 12:46 PM, Surveyor interviewed Certified Nursing Assistant (CNA) C. CNA C confirmed R7 requires 1:1 supervision at times due to behaviors. CNA C stated R7 has had several medication changes related to behaviors of wandering and verbal and physical aggression. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/07/26 at 7:28 AM, Surveyor interviewed Director of Nursing (DON) B. Surveyor discussed with DON B that R7's behaviors were not documented with corresponding number in TAR and were not consistent with progress notes. Surveyor asked DON B if there was additional documentation or evidence R7's behaviors were being tracked and monitored to ensure medications were appropriate and effective. Surveyor did not receive any additional information. Example 2 R5 was admitted to the facility on [DATE] with pertinent diagnoses of Alzheimer's disease with late onset, and dementia with anxiety. 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's care plan, dated 08/01/25, with a target date of 02/18/26, states: Resident uses anti-anxiety medications with interventions of give anti-anxiety medications ordered by physician. Monitor/document side effects and effectiveness. R5's orders: -clonazepam Oral Tablet 1 MG (Clonazepam) Give 1 mg by mouth two times a day for anxiety -Lorazepam oral tablet 0.5 mg Give 0.5 mg by mouth every 2 hours as needed for terminal agitation. -Monitor Antianxiety target behaviors: Document corresponding number that reflects the behavior presented: 0-None, 1-Hitting, 2-kicking, 3-pushing, 4-scratching, 5-grabbing, 6-threatening, 7-screaming, 8-cursing, 9-rummaging, 10-pacing, 11-restlessness, 12-fidgeting, 13-Other-see nurses note. every shift for Anti-Anxiety Med Monitoring every shift Surveyor reviewed R5's Treatment Administration Record (TAR) and Medication Administration Record (MAR) for 11/01/25 – 01/07/25 and noted: 11/01/25 – 11/30/25: all scheduled doses of clonazepam were given as ordered; 12 PRN doses of lorazepam were administered. Behaviors documented: -11/10/25 AMs – restlessness. -11/23/25 NOCs – restlessness. -11/28/25 NOCs – noted 'Other' with no additional note stating what behaviors were observed. *All other dates note no behaviors. 12/01/25 – 12/31/25: all scheduled doses of clonazepam were given as ordered; 7 PRN doses of lorazepam were administered. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Behaviors documented: -12/01/25 NOC – noted 'Other' with no additional note stating what behaviors were observed. -12/08/25 PMs – no documentation. -12/10/25 PMs – no documentation. -12/25/25 NOCs – restlessness. -12/30/25 PMs – no documentation. *All other dates note no behaviors. 01/01/26 – 01/07/25: all scheduled doses of clonazepam were given as ordered; 2 PRN doses of lorazepam were administered. Behaviors documented: None.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure a baseline care plan contained the minimum information to meet resident's immediate needs for 2 of 2 residents reviewed (R51 and R6).-Baseline care plan did not include weightbearing status related to broken humerus (R51)-Baseline care plan did not include immobilizer instructions/care (R51)-Baseline care plan did not include skin monitoring related to immobilizer (R51)-Baseline care plan did not include pain monitoring and interventions (R6) Findings include: Facility Policy titled, Care Plan Process, last revised on 11/17/23, reads in part: It is the policy of [name of facility] to develop an initial baseline care plan addressing the major area of risk within 48 hours of admission. Example 1 Occupational therapy notes from hospital, dated 12/29/25, stated R51 was to be non-weight bearing to right upper extremity and to wear immobilizer to right upper extremity at all times. Physical therapy notes from hospital, dated 12/29/25, stated, Non-weight bearing right upper extremity, shoulder immobilizer at all times. R51 was admitted to the facility on [DATE] with a right broken humerus. R51 was admitted to the facility with an immobilizer for the right upper extremity. On 01/05/26 at 10:41 AM, Surveyor interviewed R51. R51 stated the immobilizer R51 was wearing was to hold the right arm in place as it was broken. R51 stated the immobilizer was to stay on all the time. Surveyor reviewed R51's care plan. The care plan did not include any information regarding the use, care, or purpose of the immobilizer. The care plan did not include the non-weight bearing status to the right upper extremity. The care plan did not include skin monitoring related to wearing the immobilizer at all times. On 01/06/26 at 2:10 PM, Surveyor interviewed Certified Nursing Assistant (CNA) I. CNA I stated the immobilizer was on R51 to support R51's shoulder. CNA I stated R51 had a fall, and R51's arm got messed up prior to admission. CNA I stated the brace is taken off for cares with two people for stabilization and then placed back on. CNA I stated those instructions were given verbally from nursing staff. On 01/06/26 at 2:15 PM, Surveyor interviewed Licensed Practical Nurse (LPN) G. LPN G stated LPN G would have to look in the chart for information or speak with management for instruction on R51's immobilizer. LPN G was unaware of the purpose of the immobilizer. On 01/06/26 at 2:19 PM, Surveyor interviewed LPN J. LPN J stated R51 had a brace related to a broken shoulder. LPN J stated the brace only gets taken off to wash arm and then goes back on. LPN J stated LPN J understood the brace would stay on until R51 goes back to the doctor and was (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unaware of when that would be. LPN J stated normally information regarding the brace would be found in the care plan. On 01/06/26 at 2:23 PM, Surveyor interviewed Director of Nursing (DON) B. DON B stated the orders for the immobilizer and weight bearing status had not been included on the after-visit summary upon admission. DON B stated the nursing staff should have clarified both the use of the immobilizer and the weight bearing status upon admission and added it to the care plan. DON B stated nursing staff performs weekly skin checks on bathing days but did acknowledge this should have been more frequently and added to the care plan. Example 2 R6 was admitted to the facility on [DATE]. Relevant diagnoses include fracture of upper end of left humerus, low back pain, chronic pain syndrome, unspecified pain. R6's Minimum Data Set (MDS) assessment completed on 12/4/25 indicated R6 scored 14/15 during Brief Interview for Mental Status (BIMS), indicating intact cognition. R6's orders dated 12/4/25 include: Hydrocodone- Acetaminophen 5/325 milligrams (mg) tablet orally every 12 hours as needed for pain. Non-pharmacologic interventions used before, as needed (PRN) pain medication and/or before PRN pain analgesic. Document number corresponding to interventions attempted in supplementary documentation. R6's medication administration record indicated R6 received Hydrocodone- Acetaminophen 5/325 milligrams (mg) tablet orally every 12 hours as needed and R6 was given this daily from 12/4/25 until 12/8/25. However, R6's pain assessments were only documented for 12/5/25 and 12/7/25 and were both rated at a pain level of 7 on a scale of 1-10. R6's Hydrocodone- Acetaminophen 5/325 mg tablet was discontinued on 12/8/25, and R6 was prescribed Oxycodone 5 mg every 6 hours for pain. This was given as scheduled with pain assessments that ranged from 0 to 6 and change to Oxycodone 5 mg every 6 hours as needed on 12/20/25. On 1/5/26, Surveyor reviewed R6's care plan. On 12/16/25, twelve days after R6 was admitted , a focus area of acute and chronic pain were added to R6's care plan. R6's care plan updated on 12/16/25 indicated R6 has acute pain related to humerus fracture, chronic pain related to kyphosis and history of spinal fractures. Goal, pain will be managed at a level of comfort. Interventions include, offer non-pharmacological interventions such as: repositioning, toileting, offering food or drink, massage, cold packs, relaxation techniques, activities, TV, 1:1. current pain management interventions, pharmacological and non-pharmacological interventions, timeframes, and approaches for monitoring the status of the resident's pain, including the effectiveness of the interventions.On 1/05/2026 at 12:25 PM, Surveyor interviewed R6, who reported R6 has almost constant pain. R6 states R6 does take pain medication but mostly at night because R6 does not like taking too much medication. R6 also reported R6 is often uncomfortable due to anxiety. R6 does not want to take anything for R6's anxiety. Surveyor asked R6 if staff offer alternative methods such as cold packs, conversation, or massage. R6 stated staff does not offer and they do not have time. R6 stated pain is on left side, which includes shoulder arm, and entire leg. Pain comes and goes in intensity. R6 stated (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pain is worse at night because R6 cannot reposition self in bed and staff does not come in to reposition R6. On 12/17/25, R6's provider note states in part, .Patient was seen today at the request of staff due to concerns regarding pain control and anxiety . Her pain is not well controlled . On 7/7/26 at 10:25 AM, Surveyor interviewed DON B about R6 pain not being in initial baseline care plan. DON B stated the expectation would be to have R6's pain and interventions in the initial base line care plan.

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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** Based on interview and record review, the facility did not ensure care plans were revised to reflect residents' current needs and to provide the needed direction to staff in providing necessary care and services. The facility practice affected 1 of 13 resident care plans reviewed (R10).-R10's care plan was not revised after a fall. The facility policy titled, Care Plan Revision Upon Status Change, read in part, 1. The comprehensive care plan will be reviewed and revised as necessary, when a resident experiences a status change. D. The care plan will be updated with new or modified interventions.R10 was admitted to the facility on [DATE], diagnoses included Alzheimer's disease and history of falls. R10's Minimum Data Set (MDS) assessment completed on 05/02/25, confirmed R10 scored 06/10 during Brief Interview for Mental Status (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-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 [Certified Nursing Assistant] 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 [Power of Attorney] 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 [Director of Nursing] 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.

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

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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. Based on observation, interview and record review, the facility did not ensure 1 of 2 residents reviewed (R7), received the necessary services to carry out Activities of Daily Living (ADLs). -The facility identified R7 had a decline in transfer status and did not follow up with the recommended therapy evaluation. R7's Minimum Data Set (MDS) assessment, completed on 12/08/25, confirmed R7 scored 04/15 during Brief Interview for Mental Status (BIMS), indicating severely impaired cognition. R7's MDS assessment revealed R7 requires assistance with all transfers.R7's care plan included:-Resident has ADL Self Care deficit r/t alteration in functional abilities, altered cognition, dementia with behaviors, low back pain. Date Initiated: 08/27/2025 Revision on: 12/12/2025.-Resident will improve in ADL function. Date Initiated: 08/27/2025 Revision on: 12/11/2025.-Transfer: The resident is A2 with EZ stand. Date Initiated: 08/27/2025 Revision on: 12/11/2025R7's progress notes included: 12/11/25, IDT met to review change in res transfers. Staff have been using A2 with EZ stand. Will change res toileting plan to eliminate urinal as res no longer standing. Res is nearly always incontinent of urine. Discussed asking for a change to something other than po [by mouth] medication as res refuses and/or spits out meds or refuses to swallow them. Also discussed topical pain medications for the same reason. Changes to medications that res will not take are not effective. Will request PT/OT orders to address decline is functional abilities. Staff offer support to res during periods of tearfulness and withdrawal. Efforts are made to limit crowded areas that may set res off or put others at risk when res becomes agitated.During the survey period from 01/05/26-01/07/26, Surveyor observed staff assist R7 with transfers using mechanical sit-to-stand lift. On 01/05/26 at 12:46 PM, Surveyor interviewed Certified Nursing Assistant (CNA) C. CNA C confirmed R7 was assist of one for transferring, but staff have been using the sit-to-stand lift due to R7 being weak. On 01/07/26 at 12:26 PM, Surveyor asked Director of Nursing (DON) B if R7 had been referred to therapy after 12/11/25, when staff identified a change in R7's transfer status. DON B stated she didn't know about a therapy referral but would look into it. DON B asked Surveyor if the referral was made in December, and Surveyor responded it was. On 01/07/26 at 1:46 PM, DON B gave Surveyor a signed physician order for therapy evaluation related to transfers for R7, dated 01/07/26. DON B stated, I just got the order today. We discussed it but never got it.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not ensure that residents received treatment and care in accordance with professional standards of practice that would meet each resident's physical, mental, and psychosocial needs.-The facility did not obtain and enter orders for 1 of 1 resident reviewed (R51).-The facility did not update provider related to new skin impairment for 1 of 1 resident reviewed (R10).-The facility did not implement interventions to assess skin under immobilizer to prevent skin breakdown for 1 of 1 resident reviewed (R26). Findings include: Facility Policy titled, Provision of Physician Ordered Services, implemented in 2025, reads in part: The purpose of this policy is to provide a reliable process for the proper and consistent provision of physician ordered services according to professional standards of quality.Qualified nursing personnel will submit timely requests for physician ordered services (laboratory, radiology, consultations) to the appropriate entity.Documentation of consultation, diagnostic tests, the results, and date/time of Physician notification will be maintained in the resident's clinical record. Facility Assessment titled, Resident Profile, last reviewed on 09/01/25, reads in part: Specific Care or Practices for Skin Integrity includes pressure injury prevention and care, skin care, wound care.Management of Medical Conditions includes Assessment, early identification of problems.Therapy includes management of braces, splints.Provide person-centered care includes identify hazards and risks for residents. R51 was admitted to the facility on [DATE] with a high humerus fracture to the right arm. R51 was admitted with an immobilizer to right arm. On 01/05/26 at 10:41 AM, Surveyor interviewed R51. R51 was observed wearing an immobilizer around the chest with two arm straps to the right arm. R51 stated the right arm was broken and the immobilizer holds it in place. Surveyor reviewed R51's medical record and found no order in place for the immobilizer, no brace care, no weight bearing status, and no skin care associated with the brace. Care plan in place for pain related to humerus fracture, but no mention of immobilizer or skin care/impairment prevention interventions related to the immobilizer. Occupational therapy notes from hospital, dated 12/29/25, stated R51 was to be non-weight bearing to right upper extremity and to wear immobilizer to right upper extremity at all times. Physical therapy notes from hospital, dated 12/29/25, stated, Non-weightbearing right upper extremity, shoulder immobilizer at all times. Orthopedic surgery notes from hospital, dated 12/24/25, reads in part, Follow up.in one week with repeat radiographs of his shoulder.immobilizer on his right upper extremity. On 01/06/26 at 1:46 PM, Surveyor interviewed Health Unit Coordinator (HUC) S. HUC S stated there was no follow up appointment scheduled with new x-rays. HUC S stated the facility only follows the After Visit Summary (AVS) for appointments. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/06/26 at 1:48 PM, Surveyor interviewed HUC T. HUC T stated the facility follows the AVS and at times they check the hospital portal for upcoming appointments. On 01/06/26 at 2:23 PM, Surveyor interviewed Director of Nursing (DON) B. DON B stated HUC S and HUC T enter the appointments upon admission and at times, HUC S may help enter orders. DON B stated as of 12/01/25, there is an admission nurse that will usually enter orders, otherwise the floor nurses or herself enter them. DON B stated the nurses then double check the orders. DON B stated the facility uses the AVS only for appointment follow ups and admission orders because it is the most current. DON B stated the skin is checked weekly by the Certified Nursing Assistants (CNA)s on shower day. On 01/07/26 at 7:11 AM, Surveyor interviewed DON B. DON B stated after looking over the documentation, DON B was unable to locate any orders related to weight bearing status, the immobilizer, and there was no daily skin assessment in place for the resident. DON B stated none of the previous orders were added to the care plan. DON B stated the only papers that come with residents upon admission from the hospital are the AVS and discharge summary. Both documents did not have orders for a follow up appointment, the immobilizer, or weight bearing status. DON B acknowledged upon admission, orders regarding the immobilizer and weight bearing status should have been clarified. DON B reported there is now a follow-up appointment scheduled for R51. Example 2 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 LUE immobilizer on at all times except bathing or dressing. Report any redness or skin irritation to charge nurse (initiated 01/06/26). R26's orders: 01/06/25 Monitor skin under L shoulder immobilizer AM/PM. Note any redness or irritation and report to DON or wound nurse two times a day for skin monitoring. 12/09/25 Wear left shoulder immobilizer at all times (other than hygiene cares) and avoid movement of the shoulder. Wear immobilizer until cleared by orthopedic surgery every shift for shoulder dislocation. 11/18/25 Weekly Summary - Skin Condition V2 on bath days (under Assmnts) one time a day every Tue Weekly Summary - Skin Condition V2 on bath days (under Assmnts) Surveyor reviewed R26's skin assessments between 12/09/25 – 01/06/26 and noted no (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documentation of skin assessment under LUE immobilizer. On 01/06/26 at 3:25 PM, Surveyor interviewed Registered Nurse (RN) E regarding R26's skin assessments. RN E stated that CNAs look at R26's skin and inform the nurse if there are concerns. Surveyor asked RN E if the nurses remove the immobilizer and assess the skin at any time. RN E stated only if the CNAs report a concern. Surveyor asked RN E when skin assessments are completed. RN E stated only when it is assigned or ordered in the TAR. On 01/07/26 at 7:43 AM, Surveyor interviewed DON B regarding R26's skin assessments. DON B stated this should be assessed at least once a day under the device, and they would fix this issue as it could lead to skin impairment. Example 3 R10 was admitted to the facility on [DATE], with diagnoses including Alzheimer's disease. 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: Impaired skin integrity; Interventions: -Observe skin. Report any skin alterations to the charge nurse, 09/20/21. -Observe/document/report location, size, and treatment of skin injury and/or any new or worsened alterations in skin integrity, 09/20/21. On 01/03/26, R10's progress notes included, Open area to right buttock cleansed with NS, mepilex dressing applied.Surveyor was unable to find evidence of notification to provider, or a treatment order for new skin concern. On 01/06/26 at 3:33 PM, Surveyor interviewed Licensed Practical Nurse (LPN) J. LPN J stated when a new skin concern is identified, staff should update Director of Nursing and the provider. LPN J did not have knowledge of R10's new skin concern. On 01/07/26 at 7:38 AM, Surveyor interviewed DON B. DON B stated Registered Nurse (RN) H identified R10's new open area to right buttocks. DON B stated RN H is new and did not update provider. On 01/07/26 at 1:15 PM, Surveyor interviewed RN H. RN H stated she had not had training from the facility but has had from her agency. RN H stated she just started last Tuesday. RN H confirmed she observed a new open area on R10's buttocks on 01/03/25 and used standing order to apply mepilex (on Saturday). RN H did not call provider as the standing order was for 3 days and she knew she would be on in Monday morning to ask for clarification. RN H stated it did not get done on Monday morning.

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F 0686 Level of Harm - Minimal harm or potential for 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** 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 one of one resident (R) reviewed for pressure injuries (R34).The facility did not provide, document, or evaluate interventions to prevent the development of multiple pressure injuries and/or promote healing of R34's pressure injuries.Facility did not have orders or documentation to perform daily skin assessments to assess R34's skin of R34's left foot, which had a post-operative shoe due to amputaion of left great toe. The facility's lack of skin assessments of R34's left foot lead to development of a stage 2 pressure injury on toip of R34's left foot because facility did not observe that there was no cushion between the skin on R34's left foot and the post-operative shoe.Wrong Hoyer sling used on R34, which caused stage 2 sacral ulcer. No new interventions provided to promote healing.This is evidenced by:The facility's policy titled, Pressure Injury Prevention and Management, revised 10/24, states in part, .4. Interventions for Prevention and to Promote Healing . c. Evidence-based interventions for prevention will be implemented for all residents who are assessed at risk or who have a pressure injury present. Basic or routine care interventions could include . iv. Provide non-irritating surfaces . f. Interventions will be documented in the care plan and communicated to all relevant staff. g. Compliance with the interventions will be documented in the weekly summary charting.R34 was admitted to the facility on [DATE], with diagnoses including cutaneous abscess of buttock, peripheral vascular disease, venous insufficiency, acquired absence of other right toes, muscle weakness, and difficulty in walking.Skin assessment completed by the facility on 1/10/25 indicated pressure ulcer/injury (PU/PI), stage 2 of the left shin, present on admission, onset unknown. Measured 2cm long, 0.5 cm wide, and 0.1 cm deep. Foam dressing intact. Other skin issue included cellulitis.Comprehensive Minimum Data Set (MDS), dated [DATE], indicated R34 had a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device. R34's MDS indicated a Brief Interview for Mental Status (BIMS) of 15/15 indicating intact cognition.R34's hospital discharge summary included a diagnosis of pressure injury/ulcer of right heel, stage 3, and amputation of great right toe. Other issues included cellulitis of the left lower leg. Braden score completed on 1/11/25 by facility, determined R34 was at low risk for pressure ulcer development.R34 was receiving weekly skin evaluations and wound treatment at the facility by Doctor of Osteopathic Medicine (DO) U. Documentation indicated the PU/PI of R34's left shin had healed; however, R34 had developed other wounds, including a wound to the left great toe, which resulted in amputation on 10/3/25.On 9/17/25, R34 developed a new non-pressure wound of the right sacrum measured 1.2 cm long, 3.5 cm wide, and 0.1 cm deep, with moderate serous drainage, etiology documented as moisture associated skin damage and was treated by wound care provider. Daily wound care orders as follows: Right buttock wound cleanse with normal saline, apply collagen sheet to wound bed, then apply calcium alginate, use skin prep on peri wound, cover with gauze island dressing, change once dailyOn 10/29/25, DO U changed etiology of the sacral wound to trauma/injury, as it was believed to have been caused by shearing of R34's Hoyer sling. DO U also changed the location from right sacrum to the right buttock. The wound measured 1.0 cm long, 1.8 cm wide, and 0.2 cm deep (stage 2), with moderate serous drainage.On 10/3/25, R34 had amputation of appendage of left foot. R34's left foot was bandaged and R34 wore a post operative shoe per orders.On 10/13/25, R34 was seen for a post operative evaluation with orders to keep dressing intact but ok to change dressing as needed and continue with post operative shoe.On 10/17/25, Braden Scale assessment showed R34 scored 18, indicating R34 is at risk for PU/PI.On 10/27/25, R34's bandage to left foot was removed, post operative shoe was continued. The facility did perform an evaluation to determine fitting of shoe. Daily nursing skin assessment was not ordered or documented to assess skin with device use.On 10/29/25, R34 developed a new stage 2 pressure ulcer to the top of the left foot, measuring 1.8 x 2.0 x 0.1 cm, open areas with exposed dermis and with light serous drainage. DO U's (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wound evaluation note indicated, Approach stated off-loading and close monitoring.On 10/30/25, summary note indicated a new pressure area to top of left foot. Area was discovered after R34's wraps to the left foot were discontinued. Root cause analysis identified that not having something between her skin and the boot was the cause of the area. Orders to have R34 not wear this boot at this time to allow area to heal. Staff to float heels when R34 is in bed. Check skin under removable devices every shift.On 10/30/25, an order was received to discontinue use of postsurgical shoe for R34.Facility could not provide evidence of any new interventions provided with the sacral wound, even though Director of Nursing (DON) B reported it was believed to be from using and sitting on the Hoyer sling with the hole in it, which is used for toileting. DON B stated the intervention was to use the sling that was flat, as that was supposed to be used, however this was not documented anywhere or in R34's care planR34's care plan was not updated. There was no documentation of daily skin checks with use of device prior to ulceration provided.On 1/5/26 at 3:00 PM, Surveyor interviewed R34, who reported the pressure ulcer on top of her foot was from the strap of her post-surgical shoe rubbing and the wound on her sacral area is from the Hoyer lift sling. R34 showed surveyor the Hoyer sling underneath her while sitting in the wheelchair and stated it was uncomfortable at times and the need to adjust it and/or the hem where the hole is would rub where her current buttock wound is.Surveyor noted R34 had a butterfly shaped dressing approximately 10 cm x 15 cm on the sacral/buttock area and a Hoyer sling used for toileting with a hole around buttock area, was underneath R34 as she was sitting in the wheelchair. R34 stated that is the sling that is typically used and left under her,On 1/7/26 at 6:45 AM, Surveyor interviewed DON B who reported R34's sacral/buttock wound was originally identified as a moisture associated wound on R34's sacrum and then on 10/22/25, after wound DO U had a conversation with the Certified Nursing Assistants (CNA). The documentation was updated to identify the sacral wound as being on the right buttock and caused from trauma from using the wrong sling (a sling with a hole for toileting). It was identified that the CNAs were using a sling with a hole in the center for use of toileting. DON B stated once this was identified, the facility started using the correct Hoyer lift sling (without a hole). DON B reported there is no documentation the staff had been provided education on using the correct Hoyer sling after it was determined to be the cause of the PU/PI. R34's care plan was not updated with this interventionSurveyor asked DON B how the CNAs know what Hoyer sling to use and/or leave under R34. DON B stated because we told them, and they are not supposed to leave the sling with the hole in it under the resident. Interventions are not in R34's care plan, the CNA Kardex, or orders.Surveyor asked DON B for any documentation of an evaluation by a nurse or provider of R34's post-surgical shoe fitting properly, for documentation addressing an assessment of the skin under the device, and/or plan to assess R34's skin under the device (boot) on a daily basis by qualified staff. DON B reported there was not any documentation to support this.On 1/7/26 at 8:12 AM, Surveyor observed CNA V and Registered Nurse (RN) W, provide incontinence cares for R34 in bed after toileting. After providing incontinence cares in bed, staff used same sling with hole to transfer R34 back into wheelchair leaving Hoyer sling with hole in it under R34.On 1/7/26 at 8:18 AM, Surveyor interviewed CNA V asking how to determine what sling to use for R34. CNA V replied the tag on the sling indicates the size and they go by how big the resident looks. CNA V also stated they keep the sling with the hole under R34 when she is up in the wheelchair so it's easier to put R34 on the toilet.On 1/7/25 at 8:22 AM, Surveyor interviewed RN W about R34's wounds. RN W reported there is an area of concern they are watching on R34's right buttocks and top of left foot. Surveyor asked if daily wound assessments are then being documented for these areas. RN W reported daily dressing changes are being done. RN W stated they are not documenting a daily skin assessment for R34's wounds, as wound provider does it weekly.On 1/7/26 at 9:15 AM, Surveyor asked DON B to meet in R34's room. R34 was sitting in wheelchair with Hoyer sling with hole in buttock area. R34 verbalized to DON B sitting on that sling was more uncomfortable than sitting on the flat Hoyer sling, that the hem of the hole rubs on R34's sacral area and R34 thinks that may have been what caused the wound. DON B (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated R34 should not have the sling with the hole in it under her when in wheelchair. DON B reported interventions to stop using the Hoyer lift sling and to no longer use surgical shoe should have been updated in R34's care plan and were not.On 1/7/26 at 11:50 AM, Surveyor interviewed DO U. DO U stated it was determined R34's wound to the sacrum/buttocks was due to an injury suspected from the sling. Provider stated this was determined because the wound had worsened and involved deep granulation tissue, then it was suspected to be in injury resulting from the Hoyer sling.DO U stated R34's original wounds to foot were arterial, which worsened and became infected leading to R34's surgical amputation of the great left toe. DO U stated the wound to the top of R34's foot was most likely caused from the strap of the boot worn and is considered a trauma. Surveyor asked DO U if the wounds on R34's buttock/sacral area and on top of R34's L foot could have been prevented. DO U stated she would have to check with her Medical Director prior to answering that question.On 1/7/26 at 11:57 AM, Surveyor observed wound care provided for R34's wound on the right buttock (formally referred to as the sacral wound) and for the wound to the top of R34's right foot. Wound to R34's right buttock measured 0.2 x 1.0 x 0.1 cm. R34's wound to the top of the foot measured 2.1 x 2.6 x 0.1 cm.On 1/7/26 at 6:00 PM, DO U called Surveyor. After discussion of R34's wounds, DO U stated she cannot say if wounds could have been prevented because DO U Is not there 24/7.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure residents (R) with intermittent catheterization received care and treatment consistent with professional standards of practice to prevent complications or urinary tract infections (UTI) for 1 of 1 resident (R)(R4) reviewed.R4 completed self-catheterization without facility assessment and indication of need. R4 developed a UTI on 12/02/25 and 12/31/25.This is evidenced by:Facility policy titled, Catheterization of a Male, with a date of 2025, states in part: Policy: Urinary catheterization will be performed in accordance with current standards of practice to minimize risk for bacterial contamination or urethral trauma.Centers for Disease Control and Prevention (CDC) states that current standards of practice to prevent UTI and complications, intermittent catheterizations should be completed with clinical indications at regular intervals of 4-6 times daily and consider using a portable ultrasound device to assess urine volume in patients undergoing intermittent catheterization to assess urine volume to reduce unnecessary catheter insertions and prevent bladder overdistension.R4 was admitted to the facility on [DATE] with pertinent diagnoses of benign prostatic hyperplasia with lower urinary tract symptoms and retention of urine.R4's most recent quarterly Minimum Data Set (MDS) assessment, dated 11/16/25, noted a Brief Interview for Mental Status (BIMS) score of 15, indicating cognition is intact. R4 has no impairment in upper range of motion and is dependent assist with toileting hygiene. R4 uses intermittent catheterization.R4's care plan, initiated 07/22/25, with a target date of 02/18/26, states: Resident has ADL self-care deficit with interventions of toilet use: resident needs assistance with peri hygiene and pad changing.R4's care plan, initiated 04/12/23, with a target date of 02/18/26, states: R4 requires intermittent straight catheterization and will do himself with interventions of monitor and document intake and output as per facility policy and monitor for signs & symptoms (s/sx) of discomfort on urination and frequency.R4's physician orders:12/31/25 May straight cath up to 3 times per day for urinary retention.12/31/25 Levaquin 750 mg daily for 5 days.12/02/25 Bactrim 800-160 mg daily for 7 days.R4's provider notes:04/05/23 H&P: Urinary retention - R4 had an indwelling Foley catheter placed because of chronic urinary retention. He normally does straight catheterization at home and there was large and output, over 2 L, each time he catheterized himself.11/21/25 INTERVENTIONS TO MANAGE BOWEL INCONTINENCE: Res straight catheterizing 2-3 times a day to manage bladder r/t obstructive uropathy r/t prostate. Urine output is monitored TID and documented by CNA.12/08/25 - PA visit - UA on 12/02/2025 showed large blood, positive nitrite, large leukocyte esterase, trace protein, greater than 100 WBCs, greater than 100 RBCs, and bacteria present. A urine culture was not done.12/31/25 NP ASSESSMENT: Patient is being seen today for recurrent urinary tract infections. He currently self-catheterizes twice daily which he has done for the past approximately 3 years. He reports recurrent UTI symptoms with occasional stinging during urination, thick urine especially in the morning, and foul-smelling urine. He has self-catheterized for almost six years after a prolonged indwelling catheter in a nursing home. He catheterizes twice a day with 950 to 1200 mL each time and does not urinate between catheterizations. He recalls one episode of slight bleeding with thick urine and difficult catheterization. He has not seen urology since 2022, when he was evaluated for urinary retention and kidney stones. He reports careful cleaning of catheter equipment. ASSESSMENT/PLAN: Infection and Inflammatory Reaction Due to Other Urinary Catheter Subsequent Encounter Retention Urinary tract infection associated with chronic urinary retention and indwelling catheter Recurrent UTI likely due to infrequent self-catheterization, increasing retention and infection risk. - Prescribed Levaquin 750 mg once daily for 5 days due to multiple morphologies based on culture report. - Increase self-catheterization to three times daily. The fact that he only self-catheterizes twice daily could likely be contributing to his recurrent infections. - Referred to urology for further evaluation and management. Appointment scheduled for 02/12/26.Of (continued on next page)

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	525648	A. Building B. Wing	01/07/2026

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Barron Care and Rehabilitation	660 E Birch Ave Barron, WI 54812

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	note: no urology consult or assessment was documented since admission on [DATE]. No documentation from urologist indicating need for catheter was documented.Surveyor reviewed R4's nursing assessments and noted on 12/03/25, nursing completed assessment of R4 demonstrating ability to complete self-catheterization using clean technique. No other assessments were completed prior to this.Of note: no bladder assessments were documented to address number of times R4 actually completed self-catheterization, bladder scanning results, bladder training program, or characteristics of urine output.On 01/05/26 at 1:35 PM, Surveyor interviewed R4 regarding self-catheterization. Surveyor asked R4 why he needed to self-catheterize. R4 stated it was because he had an indwelling catheter in a long time ago that messed him up and now, he can't go on his own. Surveyor asked R4 if the facility has ever attempted a bladder training program. Surveyor asked R4 if he had been seen by a urologist since admitting to the facility. R4 stated no. Surveyor asked R4 how many times a day he self-catheterizes. R4 stated 3 times a day. Surveyor asked if he ever urinates without self-catheterizing. R4 stated no. Surveyor asked if the facility has ever used a bladder scanner to see how much urine is retained or assess the bladder. R4 stated no.On 01/06/25 at 1:10 PM, Surveyor interviewed Certified Nursing Assistant (CNA) D regarding R4's catheter care. CNA D stated that she thinks R4 self-catheterizes 3 times a day and the CNAs document the amount. Surveyor asked if CNAs inform the nurse regarding color, odor, or consistency. CNA D stated no, they only keep track of the output.On 01/06/25 at 3:25 PM, Surveyor interviewed Registered Nurse (RN) E regarding R4's catheter. RN E stated that R4 has self-catheterized since admission but wasn't sure exactly why he had to do this. RN E stated he thought it was due to retention. Surveyor asked RN E how often bladder assessments are completed on R4. RN E stated this is only completed if it is a task assigned in the TAR and then a progress note would be made but didn't think R4 had regular assessments completed. Surveyor asked RN E if nurses assess how often R4 is self-catheterizing. RN E stated they don't ask R4 this but know that he does it 3 times a day. Surveyor asked RN E if they ever use a bladder scanner to assess urine retention on R4. RN E stated no.On 01/07/26 at 7:29 AM, Surveyor interviewed Director of Nursing (DON) B regarding R4's catheter. Surveyor asked DON B if R4 had any evaluations completed by a urologist to state need for self-catheterization. DON B stated, she could not find anything. Surveyor asked DON B if an assessment had been completed on R4 prior to 12/03/25 for capability of R4 to complete self-catheterization. DON B stated no. Surveyor asked DON B if this should have been completed to determine any risk that could lead to UTIs or complications. DON B stated yes. Surveyor asked DON B if bladder assessments are completed regularly on R4 to monitor for complications. DON B stated no and that they probably should have. Surveyor asked DON B why R4 had an order to self-catheterize 3 times a day. DON B stated that was what R4 stated he did, so that was what they asked the provider to order.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility did not ensure pain management interventions were provided for 1 out of 2 residents (R) reviewed for pain management.The facility did not assess and provide non-pharmacologic interventions to R6 as ordered for pain management.This is evidenced by:The facility policy titled, Pain Assessment & Scale dated 4/12/2001, reads in part. 3. Consider alternative pain relief measures such as: distraction, massage, cold or warm packs, repositioning, or backrub.R6 was admitted to the facility on [DATE]. Diagnoses include fracture of upper end of left humerus. R6's Minimum Data Set (MDS) assessment completed on 12/4/25 indicated R6 scored 14/15 during Brief Interview for Mental Status (BIMS), indicating intact cognition. R6's care plan updated 12/16/25 indicated resident has acute pain related to humerus fracture, chronic pain related to kyphosis and history of spinal fractures. Goal, pain will be managed at a level of comfort. Interventions include, offer non-pharmacological interventions such as: repositioning, toileting, offering food or drink, massage, cold packs, relaxation techniques, activities, TV, 1:1. current pain management interventions, pharmacological and non-pharmacological interventions, timeframes, and approaches for monitoring the status of the resident's pain, including the effectiveness of the interventions.On 1/05/2026 at 12:25 PM, Surveyor interviewed R6, who reported R6 has almost constant pain. R6 states R6 does take pain medication but mostly at night because R6 does not like taking too much medication. R6 also reported R6 is often uncomfortable due to anxiety. R6 does not want to take anything for anxiety. Surveyor asked R6 if staff offer alternative methods such as cold packs, conversation, or massage. R6 stated staff does not offer and they do not have time.R6 stated pain is on left side, includes shoulder arm, and entire leg. Pain comes and goes in intensity. R6 stated pain is worse at night because R6 cannot reposition self in bed and staff does not come in to reposition R6. R6's orders dated 12/4/25 include:Non-Pharmacologic Interventions used before, as needed (PRN) pain medication and/or before PRN pain analgesic. Document number corresponding to interventions attempted in supplementary documentation. As needed for non-pharmacological pain interventions PRN (as needed) Non-pharmacological pain interventions 1. Reposition 2. Warm pack 3. Ice pack 4. Dimmed lighting 5. Massage 6. Music 7. Television 8. Distraction 9. 1:1 communication 10. Education provided 11. Other--Add to progress note. Measurable goals for pain management, current pain management interventions, pharmacological and non-pharmacological interventions, timeframes, and approaches for monitoring the status of the resident's pain, including the effectiveness of the interventions. R6's treatment administration record indicated there were no non-pharmacologic interventions offered from 12/4/25 until 12/25/25, then again not offered on 12/27/25, 12/29/25, 12/31/25, and 1/2/26 through 1/6/25.R6's medication administration record indicated R6 received Hydrocodone- Acetaminophen 5/325 milligrams (mg) tablet orally every 12 hours as needed and R6 was given this daily from 12/4/25 until 12/8/25. However, R6's pain assessments were only documented for 12/5/25 and 12/7/25 and were both rated at a pain level of 7 on a scale of 1-10.R6's Hydrocodone- Acetaminophen 5/325 mg tablet was discontinued on 12/8/25, and R6 was prescribed Oxycodone 5 mg every 6 hours for pain. This was given as scheduled with pain assessments that ranged from 0 to 6 and change to Oxycodone 5 mg every 6 hours as needed on 12/20/25.Starting on 12/20/25, R6's pain assessments were not done every shift and when pain assessments were completed, the pain ranged from 5 to 10 on a scale of 1-10. During survey 1/5/25 through 1/7/25, Surveyor did not observe staff offer any non-pharmacologic interventions to R6.On 1/7/26 at 10:21 AM, Surveyor interviewed Director of Nursing (DON) B about R6's pain assessments and non-pharmacologic interventions not being consistently provided. DON B stated the expectation would be R6's pain be consistently assessed and nursing interventions be documented and this was not done.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview and record review, the facility did not ensure that a resident (R) who requires dialysis receives such service, consistent with professional standards of practice for 1 of 1 sampled resident (R3) reviewed for dialysis.The facility failed to provide ongoing assessment of R3's condition and monitoring for complications before and after dialysis treatments.Findings include:R3 was admitted to the facility on [DATE] with diagnoses including chronic kidney disease, stage 4 (severe) and dependence on renal dialysis.R3 is transported to hemodialysis off site on Mondays, Wednesdays, and Fridays. R3's orders as of 10/21/25, indicate to take a full set of vitals and weight post dialysis treatment one time a day every Monday Wednesday, and Friday. Post vital signs were not taking on 11/28/25 and on 12/1/25 after R3's hemodialysis. R3's care plan states R3 requires dialysis related to renal failure with a goal to have no signs and symptoms of complications from dialysis. Interventions state in part. Check access site for bruit and thrill per nursing order on treatment assessment record, fistula/graft access site: If bleeding occurs to fistula/port site, using gauze apply pressure for 10 minutes if stops apply new gauze and tape. If does not stop send to ER. Observe and report to Nurse and/or MD as needed any signs/ symptoms of infection to access site.On 1/5/26 at 1:02 PM, Surveyor interviewed R3 who reported R3 did not have a fistula but R3 has a peripherally inserted central catheter (PICC) line. Surveyor asked R3 if staff ever observed or flushed R3's PICC line, and R3 stated the facility staff has not looked at it since R3's admission.In review of R3's medical record there are no orders, assessments, documentation, or care plan interventions in relation to R3's PICC line. R3's care plan indicates interventions for a fistula (Arteriovenous Fistulas are common in hemodialysis patients). R3 does not have a fistula.On 1/7/26 at 8:30 AM, Surveyor interviewed Registered Nurse (RN) W, who reported RN W assesses R3's fistula and then later stated RN W had R3 confused with another resident. Surveyor asked if RN W assesses R3's PICC line port. RN W stated the PICC line is covered, and dialysis takes care of the PICC line. Surveyor aske RN W if RN W documents anywhere about R3's PICC port site condition, and if the PICC line is monitored for signs of an infection or bleeding. RN W stated not that RN W is aware of.On 1/7/26 at 10:30 AM, Surveyor interviewed DON B, who verified post dialysis vital signs were missed on two days, and R3's care plan did not adequately identify or address interventions for the care of R3's PICC line.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview and record review, the facility did not ensure a medication error rate of less than 5% for 2 of 3 residents observed (R21, R22).-Facility had a medication error rate of 11.54%.-R21 received the wrong dose for two medications (artificial tears and Citalopram).-R22 received the wrong medication. R22 received Calcium with Vitamin D 500mg tab and the physician order was for Calcium Carbonate 1250 (500 Ca) and to give 2 tablets by mouth one time a day.Findings include:Facility policy titled, Medication Administration, last revised 11/25, states in part: Medications are administered to residents by qualified personnel in compliance with federal and state laws and standards of professional practice.to ensure the safe, appropriate, and accurate administration and handling of medications in a dignified manner.Licensed Nurses will . observe the seven rights of proper medication administration.right drug.right dose. On 01/06/26 at 7:22 AM, Surveyor observed Licensed Practical Nurse (LPN) F administer medications to R21. LPN F administered 1 drop of artificial tears to both R21's eyes and disposed of the one-dose vial into the garbage can. LPN F was not wearing gloves and did not follow the order for 2 drops in each eye. Surveyor observed LPN F administer oral medications to R21. LPN F administered 10mg of Citalopram to R21. Physician order states to give 30 mg by mouth one time a day for depression.On 01/06/26 at 7:46 AM, Surveyor observed LPN F administer medications to R22. LPN F administered Calcium with Vitamin D 500mg 1 tab. The physician order is for Calcium Carbonate 1250 (500 Ca) mg give 2 tablets by mouth one time a day for low amount of calcium in the blood.Surveyor reviewed orientation checklist and professional nurse orientation checklists for LPN F. Skill for using the electronic medication administration record (MAR) checked off and initialed complete on 08/15/25. Medication Pass: observation/independent pass with Nurse available, marked completed on 08/20/25.On 01/07/26 at 12:44 PM, Surveyor interviewed LPN G. LPN G stated LPN G would check the order in the MAR, check the order on the medication card, and could ask the resident their name, to ensure the proper medications were given. LPN G also stated that LPN G could check the orders if there was a discrepancy. LPN G stated that if there was an over-the-counter medication that was not clear, LPN G would clarify it with the Director of Nursing (DON) or look at the order in the chart. LPN G stated that it would be appropriate to wear gloves when feeding a resident medication when your hand may touch the resident's mouth. LPN G stated it would be appropriate to wear gloves when administering patches, eye drops, and insulin.On 01/07/26 at 12:50 PM, Surveyor interviewed Registered Nurse (RN) H. RN H stated RN would check the MAR to ensure the correct medications were given. RN H stated if RN H did not know what a medication was, RN H would look it up in the drug book. RN H stated gloves would be appropriate when administering eye drops, creams, and patches.On 01/07/26 at 2:00 PM, Surveyor interviewed Director of Nursing (DON) B. DON B stated if the nurses had an over-the-counter medication they were unsure of, they should look it up to see if there is another name for it. If it is out of stock, designated staff could run out and get it or management such as DON B or Nursing Home Administrator (NHA) A could give the pharmacy approval to send it. DON B stated the expectation is nurses should be wearing gloves with med pass, which would include anything potentially hazardous, when administering eye drops, cleaning nebulizers, any time something is inserted, and when administering creams and ointments.