| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 525654 | A. Building<br>B. Wing | 10/07/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Heritage Lakeside | 1016 Lakeshore Dr<br>Rice Lake, WI 54868 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>(continued on next page) |

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

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

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not ensure care plans met medical needs and included preferences for 1 of 3 residents (R) reviewed.R1 had a fall out of wheelchair and there was no intervention added.R1 was sitting on multiple items in the wheelchair per preference that was not noted in the care plan.CAM boot was ordered from the doctor on 09/26/25 and was not added to the care plan. Findings:The facility policy titled, Fall Protocol, states, All licensed personnel are responsible for the initiation and completion of the Risk Management when a fall occurs and the Post Fall Evaluation. Licensed Personnel will implement interventions to prevent further falls. 10. The fall and interventions should be addressed in the care plan. 17. All falls will be addressed and interventions applied. Fall Assessment: . 11. Reassess resident's environment and risk of falling. 13. Implement Immediate Intervention to prevent another fall and add Risk Management report.R1 was admitted to the facility on [DATE] with diagnoses that include a stroke affecting the right side of body and is morbidly obese. R1's Minimum Data Set (MDS) dated [DATE] indicated R1 has no cognitive impairment, understands, and is understood. R1 requires maximum assistance with bed mobility and is dependent on staff for transfers, toileting, and mobility once in a wheelchair.Surveyor reviewed the incident report that notes on 09/16/25, R1 was being transported to an appointment in wheelchair via van service. Certified Nursing Assistant (CNA) C accompanied R1. During the transport, driver applied brakes to avoid hitting a deer which led to R1 falling off the seat of the wheelchair and onto the foot pedals. Example 1On 10/07/25 at 10:06 AM, Surveyor interviewed CNA C. CNA C stated R1 was sitting on a dycem, cushion, and bath blanket to the best of her knowledge. When the driver applied the brakes, R1 slid under the safety belts and landed on the wheelchair foot pedals.On 10/07/25 at 1:15 PM, Surveyor asked for the fall incident report for R1. Director of Nursing (DON) B stated there is not one because it was only looked at as a motor vehicle accident and did not think of it as a fall, but now looking at it, it should have been looked at as a fall. Because it was not looked at as a fall, no intervention was added to R1's care plan.Example 2On 10/07/25 at 10:06 AM, Surveyor interviewed CNA C who was in the van at the time of the incident. CNA C stated R1 was sitting on a dycem, cushion, and bath blanket to the best of her knowledge. On 10/07/25 at 10:32 AM Surveyor contacted Van Service Representative (VR) D by phone and was informed that R1 used cushions under butt and behind back in the wheelchair.On 10/07/25 at 11:10 AM, Surveyor observed R1 in bed and wheelchair was in the room. R1's wheelchair seat contained a dycem, a sit steady cushion, a 2-inch cushion, sheep skin, and a bath blanket. In addition, there was a lumbar back support cushion on the wheelchair. Surveyor asked R1 if all items were used during the deer incident. R1 stated it was and prefers it that way or it would cause tailbone issues.On 10/07/25 at 1:22 PM, Director of Rehab (DR) E informed Surveyor and DON B that R1 has been and is currently using a dycem, sit steady cushion, another cushion, sheep skin, and a bath blanket in the wheelchair for fear R1 will soil the cushion. Surveyor reviewed the care plan and there was no mention of R1's preference to sit on multiple items in the wheelchair, and no mention of the lumbar back support that was used.Example 3Surveyor reviewed R1's physicians orders. Order was received on 09/26/25 that reads, in part, Patient may bear weight on right foot in CAM boot.Surveyor reviewed R1's chart and found no mention of the use of a CAM boot in R1's care plan nor on the CNA Kardex. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not ensure resident's environment was free from accidental hazards to prevent accidents for 1 of 3 residents reviewed.R1 was sitting on multiple items in a wheelchair, which contributed to R1 falling off the wheelchair seat during transport.Findings:According to Nemt Insurance article, dated 05/01/21, It is perfectly acceptable that additional cushioning may be an integral component to a wheelchair user's level of comfort. However, the cushion should be specifically designed by the manufacturer and integrated into the original design of the wheelchair by that manufacturer. If it isn't, then it should be removed from the wheelchair prior to transport in an effort to reduce the likelihood of severe injury if an accident were to occur. While a passenger's personal comfort is important; ultimately their safety, and the safety of those around them is more important.R1 was admitted to the facility on [DATE], with diagnoses that include a stroke affecting the right side of body and morbidly obese. R1's Minimum Data Set (MDS) dated [DATE] indicated R1 has no cognitive impairment, understands, and is understood. R1 requires maximum assistance with bed mobility and is dependent on staff for transfers, toileting, and mobility once in a wheelchair.Surveyor reviewed the incident report that notes on 09/16/25, R1 was being transported to an appointment in wheelchair via van service. Certified Nursing Assistant (CNA) C accompanied R1. During the transport, driver applied brakes to avoid hitting a deer, which led to R1 falling off the seat of the wheelchair and onto the foot pedals. On 10/07/25 at 10:06 AM, Surveyor interviewed CNA C. CNA C stated R1 was sitting on a dycem, cushion, and bath blanket to the best of her knowledge. When the driver applied the brakes, R1 slid under the safety belts and landed on the wheelchair foot pedals. R1's right foot got pinned between the wheelchair wheel and the seat belt device on the floor of the transportation van. CNA C and the van driver attempted to assist R1 but was unable. Van driver called 911. Paramedics arrived and lifted R1 up as another moved the wheelchair out from under R1 and lowered to the floor. From there the paramedics used a sheet to place R1 on a stretcher and transported to the hospital via ambulance.Surveyor reviewed R1's hospital records, dated 09/16/25, which identified R1 acquired a right ankle fracture. R1 was treated and sent back to the facility with follow up orders.On 10/07/25, Surveyor interviewed Director of Nursing (DON) B and asked if having R1 sit on multiple items in the wheelchair during transport contributed to a hazard. DON B said it could have been a possibility, or the driver could have also strapped the belt over the top of the abdomen instead of under it. |