

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525654	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2025
NAME OF PROVIDER OR SUPPLIER Heritage Lakeside		STREET ADDRESS, CITY, STATE, ZIP CODE 1016 Lakeshore Dr 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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51804</p> <p>Based on observation, record review and interview, the facility did not ensure 1 resident (R) of 12 sampled residents (R21) was reasonably accommodated for personal needs. R21's room is set up so that he cannot access or use his sink.</p> <p>This is evidenced by:</p> <p>R21 was admitted to the facility on [DATE] and has diagnoses that include but are not limited to: Parkinson's disease with dyskinesia, with fluctuations; difficulty in walking, not elsewhere classified.</p> <p>R21's Minimum Data Set (MDS) assessment, dated 11/19/24, indicated that R21 uses a wheelchair and a 4 wheel walker for mobility.</p> <p>R21's care plan, dated 11/26/24, states: ADL: The resident has an ADL self-care performance deficit r/t Parkinson's disease, weakness, encephalopathy.</p> <p>Ambulation: Ambulate assist of two 250', follow with w/c and use personal 4ww (leave walker in hallway after use so resident does not attempt to use on is own) or distance as tolerate by resident and safe gait pattern.</p> <p>On 01/12/2025 at 1:01 PM, Surveyor interviewed R21 and his Family Member (FM) K who stated there is an issue getting to R21's sink. Surveyor observed it was in the corner while asking for clarification. FM K stated R21 cannot get his wheelchair in the space in front of the sink, nor can he use his walker. R21 stated he can't turn his walker around. R21 stated he doesn't wash his hands, and they don't offer me a wipe either.</p> <p>On 01/13/25 at 9:21 AM, Surveyor observed R21 brushing his teeth in his room; no staff were around to assist him. Surveyor observed R21 propelling his wheelchair towards the sink. R21 was unable to get his chair into the space in front of sink. R21 tried to reach out and put kidney basin in sink. R21 was unable to reach the sink and attempted to stand. R21 was unsuccessful two times before he grabbed foot board of extra bed in front of sink and dresser to attempt to stand. There were still no staff around. Surveyor told R21 to sit and she would get him help. Surveyor got staff to assist resident.</p> <p>(continued on next page)</p>

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525654	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2025
NAME OF PROVIDER OR SUPPLIER Heritage Lakeside		STREET ADDRESS, CITY, STATE, ZIP CODE 1016 Lakeshore Dr 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)		
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/14/25 at 11:38 AM, Surveyor interviewed Certified Nursing Assistant (CNA) J about hand hygiene for residents. When asked if the resident should have washed his hands, CNA J indicated she knew R21 couldn't get to the sink.</p> <p>On 01/14/25 at 11:50 AM, Surveyor interviewed Director of Nursing (DON) B. DON B was not aware that R21 could not reach his sink.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525654	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2025
NAME OF PROVIDER OR SUPPLIER Heritage Lakeside		STREET ADDRESS, CITY, STATE, ZIP CODE 1016 Lakeshore Dr 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)		
<p>F 0620</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Not require residents to give up Medicare or Medicaid benefits, or pay privately as a condition of admission; and must tell residents what care they do not provide.</p> <p>49353</p> <p>Based on policy review and interview, the facility failed to ensure facility's admission packet did not request or require residents to waive potential facility liability for losses of personal property. This failure had the potential to affect all 33 residents residing in the facility.</p> <p>Findings include:</p> <p>Facility's Resident Handbook dated 2023, pg. 14, states in part:</p> <p>Personal Furnishings and Possessions: .Should something be missing or in need of repair inform your care team, social worker, or representative immediately so that we can assist with location or repair. Our goal is to keep your items safe, however, Heritage Lakeside is not responsible for replacing misplaced items.</p> <p>On 01/14/25 at 11:20 AM, Surveyor interviewed Nursing Home Administrator (NHA) A regarding facility policy on misappropriation of resident's property. NHA A stated the facility's resident handbook is given to all residents and clearly states the facility is not responsible for resident's missing or lost personal items. Surveyor asked NHA A if there were any variances to this policy. NHA A stated, no, that unless a missing item is directly linked to facility staff's negligence, they do not reimburse or replace residents for their missing items.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525654	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2025
NAME OF PROVIDER OR SUPPLIER Heritage Lakeside		STREET ADDRESS, CITY, STATE, ZIP CODE 1016 Lakeshore Dr 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)		
<p>F 0623</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47807</p> <p>Based on interview and record review, the facility did not ensure they notified the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. All residents investigated for hospitalization s did not receive a notice of transfer. Four of four residents (R) investigated (R21, R22, R24, R20) did not receive notice of transfer.</p> <p>Findings include:</p> <p>Example 1</p> <p>R24 was admitted to the facility on [DATE] and has diagnoses that include non-st elevation (nSTEMI) myocardial infarction, unspecified psychosis not due to a substance or known physiological condition, adult failure to thrive.</p> <p>R24's [NAME] Data Set (MDS) assessment, dated 12/08/24, indicated that R24 left and returned on 12/13/24</p> <p>Record review of progress noted dated 12/12/24 at 2:25 PM indicated that R24 On 12/8 sent to ER on , d+[DATE] report of suspected rib fracture. On 12/11 received final report and resident has a right 1st rib fracture. Resident has not complained of any pain. Pain monitoring is recorded as 0. There was no bruising noted on weekly skin sheets. Resident has remained at the same level of activity participation. Resident scheduled to return to the facility 12/13.</p> <p>R24 did return to the facility on [DATE].</p> <p>Surveyor did not receive a written copy of notification of transfer for R24 from the facility, and none was located in electronic medical records.</p> <p>Example 2</p> <p>R22 was admitted to the facility on [DATE] and has diagnoses that include respiratory failure, unspecified, unspecified whether with hypoxia or hypercapnia, unspecified severe protein-calorie malnutrition, cognitive communication deficit, abnormal weight loss, dysphagia, oropharyngeal phase</p> <p>R22's [NAME] Data Set (MDS) assessment, dated 08/24/24, indicated that R24 left and returned on 08/29/24</p> <p>Record review of progress noted dated 8/24/2024 6:30 PM, Note Text: Resident lethargic. O2 saturation at 80%. Large amounts of sputum were found in his mouth. Notified on-call and sister that resident was transported to local hospital in respiratory distress.</p> <p>Record review indicated R22 did return to the facility on [DATE].</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525654	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2025
NAME OF PROVIDER OR SUPPLIER Heritage Lakeside		STREET ADDRESS, CITY, STATE, ZIP CODE 1016 Lakeshore Dr 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)		
<p>F 0623</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Surveyor did not receive a written copy of notification of transfer for R22 from the facility, and none was located in electronic medical records.</p> <p>31086</p> <p>Example 3</p> <p>R20 was admitted to the facility on [DATE]. R20's current diagnoses include osteomyelitis ankle and foot, abnormalities of gait and mobility, muscle weakness, atrial fibrillation, DM2, peripheral venous insufficiency, displaced fracture of left calcaneus, disorders of bone density and structure.</p> <p>On 08/01/24, R20 was transferred to the emergency room then admitted to the hospital for infection requiring antibiotic therapy.</p> <p>Surveyor reviewed R20's medical record and identified no documentation of R20 receiving written notice of transfer.</p> <p>51804</p> <p>Example 4</p> <p>R21 was admitted to the facility on [DATE] and has diagnoses that include but are not limited to: Parkinson's disease with dyskinesia, with fluctuations; encephalopathy, unspecified; non-Alzheimer's dementia; needs assistance with personal care; weakness, difficulty in walking, not elsewhere classified.</p> <p>Record review identified R21 was hospitalized from 09/23/24 to 9/25/24 due to altered mental status.</p> <p>Nurses' notes dated 09/23/2024 at 11:54 AM titled Transfer to Hospital Summary states R21's wife went to the nurse and reported that R21 was not responding. The nurse checked R21 and R21 was not responding to any sternal rub, or any external stimuli. Respirations were shallow and labored. No signs of respiratory distress were noted, no facial drooping was noted, and hand grasps were even bilaterally. Facility called 911 and paramedics arrived at the facility. R21 was transferred to a local hospital. R21's wife was present in the room. Physician was notified and agreed with R21's transfer to the hospital for further evaluation. R21's vital signs were T. 98.6, P 66, R 16, O2 sat 94% at room air, B/P 155/96.</p> <p>Surveyor found a bed hold but was unable to locate a written notice of discharge/ transfer form for this hospitalization in R21's medical record. On 01/14/25 at 10:02 AM, Surveyor requested a copy of the written notice of discharge or transfer and documentation of ombudsman notification for R21's transfer to the hospital. Received a copy of the transfer/discharge report that is sent to the ombudsman for September and October 2024. No written notice of discharge received.</p> <p>On 01/12/24 at 1:04 PM, Surveyor interviewed Family Member (FM) K about recent hospitalization . FM K reported that she was here that day it happened.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525654	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2025
NAME OF PROVIDER OR SUPPLIER Heritage Lakeside		STREET ADDRESS, CITY, STATE, ZIP CODE 1016 Lakeshore Dr 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)		
<p>F 0623</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>On 01/14/25 at 9:26 AM, Surveyor interviewed Registered Nurse (RN) F regarding hospitalization process. RN F stated when the order to transfer to the hospital occurs, we call for transport if needed and call the hospital with report. Then call families to let them know they were transferred. If social services director is here, she takes care of the bed hold.</p> <p>On 01/14/25 at 9:54 AM, Surveyor asked Social Services Director (SSD) D for copy of transfer notice. Surveyor did not receive a written copy of notice of transfer from facility.</p> <p>Interviews:</p> <p>On 01/15/24 at 10:30 AM, Surveyor interviewed SSD D regarding the bed hold, transfer of notification, and ombudsman notification process for a resident needing to go to the hospital. SSD D knew they needed a bed hold and to notify the ombudsman but was confused about what a written notification of transfer might be.</p> <p>On 01/15/25 at 1:48 PM, Surveyor interviewed Director of Nursing (DON) B regarding the missing written notification of transfer. DON B was able to produce a blank copy of the transfer information they send when a resident goes to the hospital; they do not always see it because many times the resident is leaving due to an emergency. Sometimes DON B gets back this transfer information from the hospital, but not always. They would expect that a written notification of transfer be sent each time a resident is sent to the emergency room .</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525654	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2025
NAME OF PROVIDER OR SUPPLIER Heritage Lakeside		STREET ADDRESS, CITY, STATE, ZIP CODE 1016 Lakeshore Dr 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)		
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51804</p> <p>Based on observation, interview and record review, the facility did not ensure that a resident who is unable to carry out Activities of Daily Living (ADLs) receive the necessary services to maintain safety and personal hygiene (hand hygiene) for 1 out of 4 residents (R). R21 does not receive hand hygiene services after toileting or when in his room.</p> <p>This is evidenced by:</p> <p>The policy, titled Handwashing/Hand Hygiene, dated August 2019, states, This facility considers hand hygiene the primary means to prevent the spread of infections.</p> <p>R21 was admitted to the facility on [DATE] and has diagnoses that include but are not limited to: Parkinson's disease with dyskinesia, with fluctuations; non-Alzheimer's dementia; needs assistance with personal care; weakness; difficulty in walking, not elsewhere classified.</p> <p>R21's Minimum Data Set (MDS) assessment, dated 11/19/24, indicated that R21 needs assist with his personal hygiene and activities of daily living. For example, he has been assessed as needing substantial/maximum assist with toilet hygiene and personal hygiene, while oral hygiene is rated - supervision or touching assistance.</p> <p>R21's care plan, dated 11/26/24, states: ADL: The resident has an ADL self-care performance deficit r/t Parkinson's disease, weakness, encephalopathy.</p> <p>Nail care weekly on bath day .</p> <p>Personal Hygiene: extensive assist of 1</p> <p>On 01/13/2025 at 7:42 AM, Surveyor observed morning cares of R21. Certified Nursing Assistant (CNA) I assisted R21 to the bathroom. At end of cares R21's wheelchair was turned towards the door, and R21 started to self-propel to the dining room. R21 was not offered a washcloth, hand sanitizer, or opportunity to wash his hands after using bathroom or as part of his cares.</p> <p>On 01/13/2025 at 9:21 AM, Surveyor observed R21 brushing his teeth in his room. R21 was holding his kidney basin on his lap with his left hand and toothbrush in right. No staff in room to assist him.</p> <p>On 01/14/2025, at 11:27 AM, Surveyor observed CNA J assist R21 to the bathroom. CNA J used appropriate hand hygiene during intervention for self. No hand hygiene offered to R21 after toileting.</p> <p>On 01/12/2025 at 1:01 PM, Surveyor interviewed R21 and Family Member (FM) K. FM K reported there is an issue getting to R21's sink. Surveyor observed it was in the corner and asked R21 if he could get to his sink. R21 indicated his wheelchair does not fit in space in front of his sink, and he cannot manipulate his walker into the space either. R21 stated he cannot use his sink, and they do not help me wash my hands. They don't offer me a wipe either.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525654	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2025
NAME OF PROVIDER OR SUPPLIER Heritage Lakeside		STREET ADDRESS, CITY, STATE, ZIP CODE 1016 Lakeshore Dr 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)		
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 01/14/2025 at 11:38 AM, Surveyor interviewed CNA J about hand hygiene for residents. When asked if the resident should wash hands after using the bathroom, CNA J stated yes. CNA J also indicated she knew R21 couldn't get to the sink. CNA J proceeded to conclude on her own that she should have offered to assist R21 with hand hygiene.</p> <p>On 01/14/2025 at 11:50 AM, Surveyor interviewed Director of Nursing (DON) B. DON B stated her expectations are that hand hygiene be used before entering a patient room and all those times. DON B expects that staff would encourage and assist residents with hand hygiene after toileting.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525654	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2025
NAME OF PROVIDER OR SUPPLIER Heritage Lakeside		STREET ADDRESS, CITY, STATE, ZIP CODE 1016 Lakeshore Dr 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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47807</p> <p>Based on observation, interview and record review, the facility did not ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. The facility did not implement orders received for a resident with a foot wound upon reception of the order. Resident (R) 137 did not see a decline with the wound. This has the potential to effect 1 of 3 residents investigated for wound care.</p> <p>Findings include:</p> <p>The facility policy, titled Prevention of Skin Breakdown dated 07/02/2018, states, It is the policy to properly identify and assess residents whose clinical conditions increase the risk for impaired skin integrity, and pressure ulcers: to implement preventative measures; and to provide appropriate treatment modalities for ulcers according to industry standards . A . 4. implement interventions according to the resident Braden Score and/or individual risk factors identified.</p> <p>R137 was admitted to the facility on [DATE] and has diagnoses that include displaced intertrochanteric fracture of left femur, subsequent encounter for closed fracture with routine healing, type 2 diabetes mellitus without complications, charcot's joint.</p> <p>On 01/12/25, Surveyor observed R137's foot and identified a wound on the right big toe that was the size of a quarter, dark purple in color. There was no indication that treatment was being completed for the wound on the right big toe.</p> <p>Record review indicated that on 01/10/25 at 4:19pm facility performed an admission/readmission observation where they completed a skin evaluation. During the skin evaluation the facility recognized the wound on the right great toe and categorized it as a vascular wound.</p> <p>There was no indication of a venous wound in diagnosis or order to treat during record review.</p> <p>Record review of a progress note dated 01/10/25 at 3:07 PM labeled Admission Summary read, He [R137] has an open area on his right great toe that has grey colored foam and a stockinette on it. He is resting in bed at this time.</p> <p>On 01/14/25 at 8:32 AM, Surveyor observed R137's foot again and noted that no treatment had been started for R137 regarding the right big toe. Resident was sitting up finishing breakfast with feet placed on floor; feet were bare.</p> <p>On 01/14/25 at 9:44 AM, Surveyor interviewed Director of Nursing (DON) B regarding R137's big right toe and asked why they did not continue with the has grey colored foam and a stockinette on it as the resident came from the hospital with that treatment. DON B said they completed an initial assessment and there were no new orders regarding R137's foot and they were going to have a skin evaluation this Friday. Surveyor then asked DON B for the assessment and note from the medical director or nurse practitioner regarding the right big toe wound.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525654	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2025
NAME OF PROVIDER OR SUPPLIER Heritage Lakeside		STREET ADDRESS, CITY, STATE, ZIP CODE 1016 Lakeshore Dr 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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review indicated that on 01/14/25 at 10:43 AM, four days after admission, the facility completed a late entry progress note that read, 1/10/2025 14:33 Late Entry:</p> <p>Note Text: Apologize in advance for the late entry. Wound on the Left hip area is unmeasurable as there are 2 unremovable bandages at this time on the hip area. Toe is 1cm X .5 with no depth. Charge RN will get order to place mepilex over the AG on toe.</p> <p>On 01/14/25 at 11:53 AM, Surveyor interviewed DON B about the documentation about the initial assessment. DON B admitted they had found an order from Nurse Practitioner (NP) N that indicated they should have been applying a mepilex to the area starting on 01/10/25 upon admission. The order to apply the mepilex did not get into the system; the nurse on duty at the time should have put it in. DON B would expect that all orders received for residents be placed into their electronic medical record system and be followed.</p> <p>In the time that R137 entered the facility there appeared to be no changes to the condition of the wound.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525654	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2025
NAME OF PROVIDER OR SUPPLIER Heritage Lakeside		STREET ADDRESS, CITY, STATE, ZIP CODE 1016 Lakeshore Dr 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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51804</p> <p>Based on observation, interview and record review, the facility did not ensure the residents' safety through adequate supervision or use of safety devices in 2 of 4 residents, (R)21 and R30.</p> <p>Staff did not use a gait belt when transferring R21, and R21 was left unsupervised during cares.</p> <p>R30 had a recent fall with the new intervention to prevent falls not updated on the care plan.</p> <p>This is evidenced by:</p> <p>Example 1</p> <p>The policy, titled Policy NO: 007-004 Subject: Gait Belts, dated April 2023, states, It is the policy to require the use of transfer belts for resident transfer and walks as indicated in the resident's plan of care or as needed to ensure resident's safety.</p> <p>R21 was admitted to the facility on [DATE] and has diagnoses that include but are not limited to: Parkinson's disease with dyskinesia, with fluctuations; encephalopathy, unspecified; non-Alzheimer's dementia; needs assistance with personal care; weakness, difficulty in walking, not elsewhere classified.</p> <p>R21's Minimum Data Set (MDS) assessment, dated 11/19/2024, indicated that R21 needs assist with his mobility and cares. R21 requires substantial/maximum assist with toilet and personal hygiene and supervision or touching assistance with oral hygiene.</p> <p>R21's care plan, dated 11/26/2024, states: ADL: The resident has an ADL self-care performance deficit r/t Parkinson's disease, weakness, encephalopathy. Interventions include Transfer: Assist of one with 4ww (wheeled walker) . Personal Hygiene: extensive assist of 1</p> <p>FALLS: The resident is at risk for fall r/t Deconditioning, Parkinson's Disease. Interventions include Anticipate and meet the resident's needs.</p> <p>On 01/13/2025 at 9:21 AM, Surveyor observed R21 brushing his teeth in his room by himself. No staff were around to assist him.</p> <p>On 01/14/2025 at 9:14 AM, Surveyor observed R21 shower. No gait belt was used during these cares to transfer R21 to shower and from shower chair to wheelchair. Certified Nursing Assistant (CNA) H had one arm under R21's left arm and hand on waist band. CNA I had one arm under right side and arm on R21's chair.</p> <p>On 01/14/2025 at 11:27 AM, Surveyor observed CNA J assist R21 to the bathroom. CNA J assisted R21 with CNA J's arm under R21's arm and CNA J's other hand on R21's waist band of his pants. No gait belt was used. R21 used his walker to get to the bathroom. Remainder of toileting assist was appropriate. R21 transferred back to his wheelchair and still no gait belt used.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525654	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2025
NAME OF PROVIDER OR SUPPLIER Heritage Lakeside		STREET ADDRESS, CITY, STATE, ZIP CODE 1016 Lakeshore Dr 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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/14/2025 at 11:35 AM, Surveyor interviewed CNA J regarding use of gait belts. CNA J stated we only use a gait belt when R21 walks and transfers. CNA J stated she should have used a gait belt.</p> <p>On 1/14/2025 at 11:54 AM, Surveyor interviewed Director of Nursing (DON) B. DON B's expectations are that staff use gait belts with transfers when they are an assist of 1 or more. Surveyor asked for policy on gait belt use.</p> <p>On 1/14/2025 at 12:45 PM, Surveyor interviewed Physician Therapist (PT) G. PT G indicated he would expect staff to follow the care plan. PT G stated he would expect all staff to use a gait belt on patients with assist of at least 1.</p> <p>49353</p> <p>Example 2</p> <p>Facility policy titled, Falls and Fall Risk, Managing, with a revised date of 03/2018, stated in part:</p> <p>Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risk and causes to try to prevent the resident from falling and to try to minimize complications from falling.</p> <p>Resident-Centered Approaches to Managing Falls and Fall Risk</p> <p>1. The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls.</p> <p>5. If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant.</p> <p>Monitoring Subsequent Falls and Fall Risk</p> <p>3. If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions.</p> <p>R30 was admitted to the facility on [DATE] with pertinent diagnoses of dementia and history of falls.</p> <p>R30's most recent Minimum Data Set (MDS) dated [DATE] noted a Brief Interview for Mental Status (BIMS) score of 3 out of 15 indicating severe cognitive impairment. R30 was noted to use a walker and wheelchair for mobility and required partial assist with ambulating up to 50 feet. R30 is frequently incontinent of bowel and bladder.</p> <p>R30's care plan initiated on 07/12/24 included:</p> <p>FOCUS: The resident has an ADL self-care performance deficit r/t activity intolerance, Alzheimer's, dementia.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525654	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2025
NAME OF PROVIDER OR SUPPLIER Heritage Lakeside		STREET ADDRESS, CITY, STATE, ZIP CODE 1016 Lakeshore Dr 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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>GOAL: Target Date 02/12/25 - The resident will maintain current level of function through the review date. Resident is on hospice services, decline in health is expected.</p> <p>INTERVENTIONS:</p> <p>Ambulation: Ambulate resident with front wheeled walker 200' or as tolerated, follow with wheelchair as she tolerates.</p> <p>Personal hygiene/oral care: Extensive assist of 1</p> <p>Toilet use: Extensive assist of 1</p> <p>Transfer: Limited assist of 1</p> <p>FOCUS: Revised 10/24/24 - Falls: The resident is at risk for falls related to confusion, gait/balance problems, psychoactive drug use, unaware of safety needs, in on hospice.</p> <p>08/26/24</p> <p>09/04/24 - Resident fell walking in her room - no injuries</p> <p>10/16/24</p> <p>GOAL: Target date 02/12/25 - The resident will be free of major injury through the review date.</p> <p>INTERVENTIONS:</p> <p>-Anticipate and meet the resident's needs.</p> <p>-Check on resident frequently and offer to toilet/bedpan and/or check and change incontinent product on each shift.</p> <p>-Complete fall risk assessment per facility policy.</p> <p>-Ensure that the resident is wearing appropriate footwear (non-slip) when ambulating or mobilizing in wheelchair.</p> <p>-Follow facility fall protocol.</p> <p>-Gripper socks on at all times.</p> <p>-Offer toileting at 6am.</p> <p>-Resident needs cues to stay on task at meals, offered fluids in-between meals, likes ice cream.</p> <p>-Review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter remove any potential causes if possible. Educated resident/family/caregivers/IDT to causes.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525654	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2025
NAME OF PROVIDER OR SUPPLIER Heritage Lakeside		STREET ADDRESS, CITY, STATE, ZIP CODE 1016 Lakeshore Dr 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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Surveyor reviewed R30's most recent fall risk assessment completed 12/30/24 and noted a score of 27 indicating moderate risk.</p> <p>Surveyor reviewed R30's falls documentation and noted the following:</p> <ul style="list-style-type: none"> -On 11/17/24 had a fall: Interventions: move closer to nursing station to be more visible to staff. -On 12/20/24 had a fall: Interventions: will toilet at 6am in mornings -On 12/28/24 had a fall: Interventions: encourage resident to use call light for assist, staff to continue close monitoring. -On 12/30/24 had a fall: Interventions: resident toileted and got up before supper. <p>Surveyor could not locate the 12/30/24 fall intervention, Resident toileted and gotten up before supper, on the care plan.</p> <p>On 01/15/25 at 1:50 PM, Surveyor interviewed Director of Nursing (DON) B. Surveyor asked DON B if R30's care plan was updated to include new fall interventions after last documented fall on 12/30/24. DON B stated it should have but was unable to provide documentation. DON B stated recognition of missing this intervention being added to the care plan to prevent further falls as this could lead to injury or harm to the resident.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525654	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2025
NAME OF PROVIDER OR SUPPLIER Heritage Lakeside		STREET ADDRESS, CITY, STATE, ZIP CODE 1016 Lakeshore Dr 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)		
<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47807</p> <p>Based on interview and record review, the facility did not ensure that a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. The facility was not able to produce a reason to have Resident (R) 24's catheter changed on a monthly basis. This had the potential to affect 1 of 1 resident observed for catheter care (R24).</p> <p>Findings include:</p> <p>The Centers for Disease Control and Prevention (CDC) suggests changing indwelling catheters or drainage bags at routine, fixed intervals is not recommended. Rather, it is suggested to change catheters and drainage bags based on clinical indications such as infection, obstruction, or when the closed system is compromised.</p> <p>The facility policy that was received from the facility titled Foley Catheter Insertion, Male Resident which was not given a review data, did not have any standards regarding the standards of practice for frequency of catheter removal.</p> <p>R24 was admitted to the facility on [DATE] and has diagnoses that include respiratory failure, unspecified, unspecified whether with hypoxia or hypercapnia, unspecified severe protein-calorie malnutrition, cognitive communication deficit, abnormal weight loss, dysphagia, oropharyngeal phase</p> <p>Record review revealed orders for R24 that read, Indwelling Foley catheter, 16 French, 10cc balloon. Insert today and change every 23 days and PRN one time only for urinary retention until 10/23/2024 23:59 AND one time a day starting on the 23rd and ending on the 24th every month for urinary retention.</p> <p>Record review of the Treatment Administration Record (TAR) indicated that R24's catheter was being changed monthly.</p> <p>On 01/15/25 at 11:01 AM, Surveyor asked Director of Nursing (DON) B for physician justification beyond urinary retention to have R24's catheter changed monthly. DON B said they would need to look for it and possibly reach out to urology, but they should have record somewhere.</p> <p>Record review of progress notes dated 01/15/25 at 12:20 indicated, Data: Faxed request for STAT med records for urology visit at MMC RL (Marshfield Medical Center Rice Lake) 12/17/24. Called and they request that a fax request be sent.</p> <p>The facility was not able to provide a medical reason for the monthly changing of R24's catheter prior to the end of the survey when surveyors left.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525654	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2025
NAME OF PROVIDER OR SUPPLIER Heritage Lakeside		STREET ADDRESS, CITY, STATE, ZIP CODE 1016 Lakeshore Dr 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)		
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49353</p> <p>Based on interview and record review, the facility failed to ensure that services for a resident who needs respiratory care, is provided such care, consistent with professional standards of practice, for 1 of 1 residents (R) R18 reviewed for respiratory assessment related to medication administration.</p> <p>R18 was administered a nebulizer treatment without a lung assessment completed prior to and after treatment.</p> <p>Findings include:</p> <p>According to the National Library of Medicine (2021), the standard of nursing care expected with small volume nebulizer treatment includes: .respiratory assessment pre/post treatment, respiratory rate, heart rate, and oxygen saturation. After treatment, the patient should be encouraged to cough and perform oral care. The patient's respiratory system should be reevaluated after the administration of inhaled medications to document therapeutic effects, as well as to monitor for adverse effects.</p> <p>R18 was admitted to the facility on [DATE] with a pertinent diagnosis of chronic obstructive pulmonary disorder (COPD).</p> <p>R18's care plan initiated on 07/03/24 included:</p> <p>FOCUS: The resident has emphysema/COPD related to history of smoking.</p> <p>GOAL: The resident will be free of signs/symptoms of respiratory infections through review date.</p> <p>INTERVENTIONS: Give aerosol or bronchodilators as ordered. Monitor/document and side effects and effectiveness.</p> <p>R18's orders included:</p> <p>-08/12/24: Budesonide inhalation suspension 0.5mg/2ml - Give 2ml inhaled orally via nebulizer every 12 hours for shortness of breath, wheezing. Rinse mouth and expectorate after use.</p> <p>-11/12/24: Self-administration of nebulizer treatments after staff set up.</p> <p>On 01/13/25 at 9:50 AM, Surveyor observed Registered Nurse (RN) C obtain R18's pulse and oxygen saturation prior to administration of R18's nebulizer treatment. RN C poured nebulizer suspension into R18's nebulizer canister on bedside table and positioned oxygen mask on face. RN C ensured mask was fitted appropriately and moved R18 into upright position. RN C turned on machine to start treatment and left room. RN C did not complete a lung assessment prior to starting nebulizer treatment.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525654	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2025
NAME OF PROVIDER OR SUPPLIER Heritage Lakeside		STREET ADDRESS, CITY, STATE, ZIP CODE 1016 Lakeshore Dr 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)		
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 01/13/25 at 10:55 AM, Surveyor interviewed RN C regarding nebulizer treatments. Surveyor asked RN C what the standard of practice is associated with administering nebulizers. RN C stated that a pulse and lung sounds should be completed prior to and after treatment. Surveyor asked why this was not completed. RN C stated that it wasn't attached to the order with the nebulizer, so she didn't think about it. RN C stated that lung sounds aren't typically assessed with nebulizer treatments unless the doctor orders it. Surveyor asked if the facility provided any training or education on assessments with medication administration. RN C stated nothing specific to lung assessments and neb treatments. Surveyor asked RN C if the nurse goes back after treatment to assess. RN C stated that R18 will put call light on when the neb is finished and whoever answers the light will rinse the cup and place it back on table. No assessment or post treatment care is provided.</p> <p>On 01/13/25 at 12:49 PM, Surveyor interviewed R18 about nebulizer treatments. R18 stated that nursing staff has never listened to lung sounds prior to or after a neb treatment. Surveyor asked R18 if he is asked to rinse mouth out or expectorate after treatment. R18 stated he has never been asked to do either of those.</p> <p>On 01/15/25 at 1:50 PM, Surveyor interviewed Director of Nursing (DON) B regarding assessments with nebulizer treatments. DON B stated the facility does not have a policy or standard of practice for nursing staff to assess lungs with a neb treatment unless the doctor orders it specifically. DON B stated that nursing staff is expected to follow the doctor's orders associated with medication administration. DON B stated not being aware that a lung assessment would be considered a standard of practice when administering a nebulizer treatment.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525654	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2025
NAME OF PROVIDER OR SUPPLIER Heritage Lakeside		STREET ADDRESS, CITY, STATE, ZIP CODE 1016 Lakeshore Dr 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)		
<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care or services that was trauma informed and/or culturally competent.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31086</p> <p>Based on record review and interview, the facility did not ensure 1 of 1 resident ((R)27) who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for resident's experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident.</p> <p>This is evidenced by:</p> <p>R27 was admitted to the facility on [DATE] with current diagnoses of protein-calorie malnutrition, difficulty walking, attention deficit hyperactivity disorder (ADHD), post-traumatic stress disorder (PTSD), and major depression.</p> <p>Minimum Data Set (MDS) dated [DATE] a quarterly assessment documented R27's Brief Interview of Mental Status score of 11, indicating moderate cognitive impairment. R27's depression screen PHQ -9 score of 12, indicating moderate depression severity. The MDS documented R27 would often socially isolate.</p> <p>The facility did not comprehensively assess history of trauma, triggers which may cause re-traumatization, and approaches to eliminate re-traumatization.</p> <p>Review of R27's care plan did not have a plan for trauma-informed care to recognize and respond to triggers which may re-traumatize and interventions to minimize or eliminate the effect of the trigger. The care plan did not have resident personal cultural preferences, resident-specific approaches to prevent re-traumatization.</p> <p>The facility did not monitor and assess to ensure the effectiveness of the interventions in achieving measurable objectives and meeting resident goals.</p> <p>On 01/15/25 at 9:34 AM, Surveyor interviewed Certified Nursing Assistant (CNA) I about R27's past trauma, type of behaviors and the triggers. CNA I indicated R27 does not have behaviors and CNA I is not aware of R27 having past trauma.</p> <p>On 01/15/25 at 2:55 PM, Surveyor interviewed Director of Nursing (DON) B about the assessment and plan of care for R27's past trauma. DON B indicated the Social Services Director (SSD) D was not completing the care plan for PTSD. SSD D would do the assessment on admission with no further care planning and no follow-up assessments.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525654	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2025
NAME OF PROVIDER OR SUPPLIER Heritage Lakeside		STREET ADDRESS, CITY, STATE, ZIP CODE 1016 Lakeshore Dr 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)		
<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>47807</p> <p>Based on observation, interview and record review, the facility did not post the required daily information correctly. The facility did not ensure to include the resident census and facility name on all daily postings in the last 30 days. This has the ability to affect all 33 of 33 residents.</p> <p>Findings include:</p> <p>On 01/13/25 at 2:10 PM, Surveyor observed daily posting located next to the elevator near the entrance. The daily posting was missing the daily resident census and the title of the facility.</p> <p>On 01/15/25 at 11:17 AM, Surveyor observed daily posting located next to the elevator near the entrance. The daily posting was missing the daily resident census and the title of the facility.</p> <p>On 01/15/25 at 12:30 PM, Surveyor reviewed last 30 daily postings. 17 of the postings were missing the daily resident census. Out of the last 30 postings, six were missing the facility name. Out of the last 30 postings, six were missing both facility name and resident census.</p> <p>On 01/15/25 at 1:38 PM, Surveyor interviewed Director of Nursing (DON) B regarding expectations for daily facility postings. DON B would expect that all required information be on each of the daily postings, and they would need to create a better system to ensure that is happening.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525654	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2025
NAME OF PROVIDER OR SUPPLIER Heritage Lakeside		STREET ADDRESS, CITY, STATE, ZIP CODE 1016 Lakeshore Dr 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)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51804</p> <p>Based on observations and record review, the facility did not ensure drugs and biologicals were stored in accordance with currently accepted professional practice. This had the potential to affect 7 out of 7 residents (R) (R2, R14, R17, R20, R32, R33, R136) for proper storage and 1 of 1 resident (R) (R18) for proper labeling.</p> <p>16 new unopened insulin pens and one bottle of Humalog were found in an out of temperature range refrigerator.</p> <p>R18 did not have an accurate label for insulin.</p> <p>Findings include:</p> <p>Example 1</p> <p>The facility policy, titled Storage of Medications, dated November 2020, states:</p> <p>. The facility stores all drugs and biologicals in a safe, secure, and orderly manner.</p> <p>3. The nursing staff is responsible for maintaining medication storage and preparations areas in a clean, safe, and sanitary manner.</p> <p>7. Medications requiring refrigeration are stored in a refrigerator located in the drug room at the nurses' station or other secured locations .</p> <p>The facility policy, titled Refrigerators and Freezers, dated December 2014, states:</p> <p>Policy Statement- This facility will ensure safe refrigerator and freezer maintenance, temperatures, and sanitation, and will observe food expiration guidelines.</p> <p>1. Acceptable temperature ranges are 35 F to 40 F for refrigerators and less than 0 F for freezers.</p> <p>2. Monthly tracking sheets for all refrigerators and freezers will be posted to record temperatures.</p> <p>The Wisconsin Department of Health Services document titled, Insulin Storage Guide, dated June 2023, states: Insulin is available from drug manufacturers in two basic packages- vials and pens. General insulin storage requirements are as follows:</p> <p>1. Never freeze; frozen insulin should be thrown away.</p> <p>6. Unopened, not-in-use insulin should be stored in a refrigerator at a temperature of 36 F-46 F.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525654	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2025
NAME OF PROVIDER OR SUPPLIER Heritage Lakeside		STREET ADDRESS, CITY, STATE, ZIP CODE 1016 Lakeshore Dr 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)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 01/15/2025 at 7:35 AM, Surveyor observed the east wing medication refrigerator thermometer reading 28 F. There was ice buildup around freezer tray and a container with 16 insulin pens and one vial on the top shelf just underneath the ice.</p> <p>On 01/15/2025 at 7:35 AM, Surveyor observed the east wing medication refrigerator temperature logs were half completed for November 2024, no log for December 2024, and January 2025 log to date missed two dates. According to the January 2025 refrigerator log, it was out of range 5 days out of 12 entries (the two dates missed not counted), and was below freezing on 1/7/2025 - 30 F, 1/8/2025-28 F, and 1/9/2025- 30 F.</p> <p>On 01/15/2025 at 7:55 AM, Surveyor interviewed Director of Nursing (DON) B, who stated her expectation is that the nursing staff maintain the refrigerators, temperature logs, and storage of medication.</p> <p>49353</p> <p>Example 2</p> <p>Facility policy titled, Storage of Medications, with no date states in part:</p> <p>The facility stores all drugs and biologicals in a safe, secure, and orderly manner.</p> <p>4. Drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling before storing.</p> <p>Current Wisconsin State pharmacy labeling requirements effective December 2020 state all prescription medications must include in part: .patient name, date of birth, name and strength of medication, dosage, route .</p> <p>R18 was admitted to the facility on [DATE] with pertinent diagnosis of diabetes mellitus II.</p> <p>R18's physician orders include:</p> <p>-06/29/24 Lantus SoloStar Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Glargine)</p> <p>Inject 25 unit subcutaneously at bedtime for blood sugar control</p> <p>-08/13/24 Lantus Subcutaneous Solution 100 UNIT/ML (Insulin Glargine)</p> <p>Inject 25 unit subcutaneously in the morning for diabetes</p> <p>On 01/13/25 at 9:50 AM, Surveyor observed Registered Nurse (RN) C complete medication administration of insulin for R18. Surveyor observed lantus insulin injection pen with a pharmacy label that stated, Inject 25 units subcutaneously at bedtime for blood sugar control. The opened date stated 01/07 and expiration date of 02/07. Surveyor had RN C verify order prior to administration of insulin. Surveyor verified two orders for lantus to be administered daily.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525654	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2025
NAME OF PROVIDER OR SUPPLIER Heritage Lakeside		STREET ADDRESS, CITY, STATE, ZIP CODE 1016 Lakeshore Dr 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)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 01/13/25 at 9:53 AM, Surveyor interviewed RN C who stated the label hadn't been updated after an additional order for lantus had been added by the provider. Surveyor asked RN C what the facility policy is regarding pharmacy label not matching the physician order. RN C stated the medication should be sent back to pharmacy to be correctly labeled.</p> <p>On 01/15/25 at 1:50 PM, Surveyor interviewed Director of Nursing (DON) B regarding labeling of medications. DON B stated when a medication label does not match the order the expectation is for the nurse to send it back to pharmacy to be correctly labeled. DON B stated recognition that this had the potential to cause harm if the wrong medication had been administered and would re-educate staff on facility policy for correct medication labeling.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525654	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2025
NAME OF PROVIDER OR SUPPLIER Heritage Lakeside		STREET ADDRESS, CITY, STATE, ZIP CODE 1016 Lakeshore Dr 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)		
<p>F 0790</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide routine and 24-hour emergency dental care for each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49353</p> <p>Based on observation, interview and record review, the facility failed to have a policy identifying those circumstances when loss or damage of dentures is the facility's responsibility. This has the potential to affect all 33 residents residing in the facility.</p> <p>The facility failed to promptly, within 3 days, refer residents with lost or damaged dentures for dental services for 1 of 1 (R5) resident reviewed for missing dentures.</p> <p>R5's partial upper denture was lost on 11/01/24. They were not replaced and dental services were not provided after dentures were missing.</p> <p>Findings include:</p> <p>The facility was unable to provide Surveyor with a policy specific to missing dentures.</p> <p>R5 was admitted to the facility on [DATE] with pertinent diagnoses of diabetes mellitus II, anemia, anxiety, and cognitive communication deficit.</p> <p>R5's most recent Minimum Data Set (MDS) assessment dated [DATE] noted a Brief Interview for Mental Status (BIMS) score of 15 indicating cognition is intact, makes self understood, and able to understand others. R5 had missing or fractured teeth and needed set-up assistance for oral hygiene.</p> <p>R5's care plan dated 09/21/22 noted: The resident has an ADL self-care performance with an intervention of supervision while eating. 1. Upright position for all snacks, meds and meals. 2. Alternate food and drink. 3. Remain upright for 30 minutes after meal.</p> <p>Surveyor reviewed R5's orders and noted:</p> <p>Diet: CCHO, 2 gm Na+ diet, Regular texture, Thin/regular liquids consistency</p> <p>IDDSI 7 - Regular texture 1. Upright position for all snacks, meds and meals. 2. Alternate food and drink. 3. Remain upright for 30 minutes after meal.</p> <p>Surveyor reviewed R5's weight and noted no concerns of weight loss.</p> <p>Surveyor reviewed R5's nursing notes and noted the following:</p> <p>- 11/21/2024 14:54 Resident was a little upset today due to her teeth still missing. She refuse for any of the nurses or CNA's to look around the room to help find the teeth. Resident states I just want to be alone I would do much better if I find my teeth that was thrown away.</p> <p>Surveyor reviewed R5's dental visit notes and noted the following:</p> <p>- 7/8/24: LTC Dental - states Maxillary denture [AGE] years old. In great shape. Made with metal cast frame.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525654	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2025
NAME OF PROVIDER OR SUPPLIER Heritage Lakeside		STREET ADDRESS, CITY, STATE, ZIP CODE 1016 Lakeshore Dr 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)		
<p>F 0790</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>No additional dental visit notes made after this date.</p> <p>On 01/12/25 at 9:03 AM, Surveyor observed R5 in room. R5 was missing upper front teeth. R5 was able to safely drink fluids without difficulty.</p> <p>On 01/12/25 at 9:05 AM, Surveyor interviewed R5 regarding missing teeth. R5 stated that she was admitted to the facility with an upper partial denture. R5 stated she lost her dentures recently but was unable to state exact date they were lost. R5 stated she reported her missing dentures to the Certified Nursing Assistants (CNAs), nurses, Social Services Director (SSD) D, and Nursing Home Administrator (NHA) A. Surveyor asked if the facility had completed an investigation of the missing dentures. R5 stated the facility told her they tried looking for them, could not find them, and there was nothing more they could do. Surveyor asked if R5 was assisted in seeing the dentist after dentures were missing. R5 stated no. Surveyor asked R5 how the missing dentures have affected her quality of life. R5 stated that she struggles with eating because the teeth missing are the ones she needs to bite and chew. R5 denies any weight loss, but that her missing dentures make her self-conscious to speak in front of people now. Surveyor asked R5 if the facility offered to replace or reimburse for the missing dentures. R5 stated that NHA A told her the facility is not responsible for replacing her dentures.</p> <p>On 01/13/25, Surveyor reviewed the complaint/grievance form dated 11/01/24 indicating R5 reported dentures missing. On 11/06/24, SSD D noted herself and NHA A were the parties responsible for investigating complaint. SSD D noted that R5's teeth were in her room at the time they were lost, have not been located, and the business office will work with R5 to get Medicaid open and schedule dental appointment to get new dentures. On 11/07/24, SSD D noted that complaint/grievance is resolved with a comment, Resident wants dentures, but currently has no means to do so.</p> <p>No follow-up documentation noted with business office for Medicaid following 11/07/24. No dental appointments were scheduled after 11/07/24.</p> <p>On 01/14/25 at 9:45 AM, Surveyor interviewed SSD D regarding the process for missing items. SSD D stated that residents report missing items to nursing staff and then report to SSD D, who then initiates a grievance/complaint. SSD D stated the investigation of the missing item will be assigned based on the item. Surveyor asked SSD D about the investigation for R5's missing dentures. SSD D stated that she initiated and investigated R5's complaint of missing dentures. SSD D stated herself, nursing staff, and housekeeping looked for the dentures but were unable to locate them. Surveyor asked if SSD D offered to replace R5's dentures. SSD D stated no but that NHA A had been working more closely with R5 regarding this matter.</p> <p>On 01/14/25 at 11:20 AM, Surveyor interviewed NHA A regarding missing denture policy. NHA A stated the facility did not have a policy specific to lost or missing dentures. NHA A stated the facility is not responsible for resident's missing or lost items unless it can be proven to be facility staff negligence. Surveyor asked if the facility provided R5 dental care after losing her dentures. NHA stated no because R5 did not have any money to pay for new dentures and the facility did not lose them, so the facility is not going to pay for them. Surveyor asked NHA A how it was determined the facility was not responsible for the lost dentures if the facility did not have a policy/procedure to follow. NHA A provided Surveyor the resident handbook and stated the handbook is given to all residents on admission which outlines the facility's policy on missing dentures or other missing items. NHA A stated that it clearly states the facility is not responsible for lost or missing personal items.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525654	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2025
NAME OF PROVIDER OR SUPPLIER Heritage Lakeside		STREET ADDRESS, CITY, STATE, ZIP CODE 1016 Lakeshore Dr 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)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>47807</p> <p>Based on observation, interview and policy review, the facility did not ensure they stored, prepared, distributed, and served food in accordance with professional standards for food policy safety. The facility failed to label and date perishable items found in the refrigerator. This has the potential to affect all 33 of 33 residents residing in the facility.</p> <p>Findings include:</p> <p>The facility policy, titled Food Storage, dated 09/23/24, states, 12. Leftover food will be stored in covered containers or wrapped carefully and securely. Each item will be clearly labeled and dated before being refrigerated. Leftover food is used within 7 days or discarded as per the 2022 Federal food code.</p> <p>On 01/12/25 at 8:53 AM, during initial brief tour of the kitchen, Surveyor observed food items in the refrigerator were not labeled correctly. Surveyor observed an open bag of cherry jam dated December 2nd as the open date. Surveyor observed chopped onions in the refrigerator that were in a container not labeled. Surveyor observed an open milk jug that was half empty not labeled with an open date. Surveyor observed a V8 100% Vegetable juice that was half drunk and noticeably separated, with the only date on the juice being July 8th. Lastly, Surveyor observed a tub of leftover pulled pork that had not been labeled or dated on the container.</p> <p>On 01/12/25 at 9:15 AM, Surveyor interviewed interim Kitchen Supervisor (KS) L regarding food labeling in the refrigerator. KS L admitted the food should have been labeled if it was not and if the food was past the seven days date it should have been thrown out. KS L believed the V8 juice probably had the received date on it, but without a clear open date they had no way to confirm the open date of the V8 juice. KS L confirmed that staff should be labeling all leftovers and items that are opened in the refrigerator with open dates and throwing away if not used in seven days.</p> <p>On 01/14/25 at 9:10 AM, Surveyor interviewed Registered Dietitian (RD) M regarding leftover policy. RDM stated they had switched to the seven day plan as per their policy and the federal food code; however, they agree that milk and other items needed to be labeled with open dates. They did education already and made sure everyone has their black sharpie ready. RD M would expect the food be labeled appropriately and if it is past the seven days thrown out.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525654	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2025
NAME OF PROVIDER OR SUPPLIER Heritage Lakeside		STREET ADDRESS, CITY, STATE, ZIP CODE 1016 Lakeshore Dr 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)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49353</p> <p>Based on observation, interview and record review, the facility did not maintain an infection prevention and control program designed to help prevent the development and transmission of communicable diseases and infections for 2 out of 4 residents (R18, R22) during care observations.</p> <p>Staff did not complete hand hygiene during personal cares for 1 of 4 residents (R18) during personal cares.</p> <p>Staff did not disinfect reusable medical equipment after use with R18.</p> <p>R22 did not have enhanced barrier precautions (EBP) in place.</p> <p>Findings include:</p> <p>Example 1</p> <p>Facility policy titled, Handwashing/Hand Hygiene, with a revised date of 08/2019, stated in part:</p> <p>This facility considers hand hygiene the primary means to prevent the spread of infections.</p> <ol style="list-style-type: none"> 1. All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. 7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: <ol style="list-style-type: none"> b. Before and after direct contact with residents; <ol style="list-style-type: none"> i. After contact with resident's intact skin; l. After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident; m. After removing gloves; 8. Hand hygiene is the final step after removing and disposing of personal protective equipment. 9. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections. <p>R18 was admitted to the facility on [DATE] with pertinent diagnoses of diabetes mellitus II and COPD.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525654	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2025
NAME OF PROVIDER OR SUPPLIER Heritage Lakeside		STREET ADDRESS, CITY, STATE, ZIP CODE 1016 Lakeshore Dr 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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R18's most recent Minimum Data Set (MDS) dated [DATE] noted a Brief Interview for Mental Status (BIMS) score of 15 indicating cognition is intact, has the ability to understand and makes self understood.</p> <p>R18's care plan initiated on 07/03/24 included ADL assist of 1 with personal hygiene cares.</p> <p>On 01/13/25 at 9:37 AM, Surveyor observed Certified Nursing Assistant (CNA) E assist R18 with personal hygiene cares. R18 completed hand hygiene and donned gloves, brought wash basin with water, and washcloths and placed on R18's bedside table. CNA E completed peri care for R18. Without removing dirty gloves and completing hand hygiene, CNA E then changed the lift shift positioned under R18, placed blanket on top of R18, disposed of washcloth and used wash basin water in sink, moved the bedside table for R18 next to bed, placed call light on bed, and handed R18 his personal cell phone. Before exiting room, CNA E then removed gloves and completed hand hygiene with soap and water at the sink in R18's room.</p> <p>On 01/15/25 at 1:50 PM, Surveyor interviewed Director of Nursing (DON) B regarding observation of personal cares. DON B stated disappointment with CNA E not completing hand hygiene in-between cares as all staff are repeatedly educated on infection control policies. DON B stated re-education would be completed with staff as she recognizes the risk of infection with not completing hand hygiene during direct patient care.</p> <p>Example 2</p> <p>Facility policy titled, Cleaning and Disinfection of Resident-Care Items and Equipment, with a revised date of 10/2018, stated in part:</p> <p>Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC recommendations for disinfection and the OSHA bloodborne pathogens standard.</p> <p>c. Non-critical items are those that come in contact with intact skin but not mucous membranes.</p> <p>(1) Non-critical resident-care items include bedpans, blood pressure cuffs, crutches and computers.</p> <p>d. Reusable items are cleaned and disinfected or sterilized between residents (e.g., stethoscopes, durable medical equipment).</p> <p>On 01/13/25 at 9:50 AM, Surveyor observed Registered Nurse (RN) C complete medication administration. Prior to administering medications, RN C completed a vitals assessment of blood pressure, pulse, and pulse oxygenation reading on R18. RN C was observed removing the reusable equipment of a blood pressure cuff and pulse oximeter stored in the medication cart to complete assessment. Surveyor observed RN C complete the assessment with the reusable equipment and place items back in the medication cart without disinfecting the equipment after use.</p> <p>On 01/13/25 at 10:55 AM, Surveyor interviewed RN C regarding disinfection of blood pressure cuff and pulse oximeter. RN C stated that she realized afterward that she did not disinfect the equipment before returning it to the medication cart. RN C stated that she just forgot and she would have normally disinfected it after use on a resident.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525654	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2025
NAME OF PROVIDER OR SUPPLIER Heritage Lakeside		STREET ADDRESS, CITY, STATE, ZIP CODE 1016 Lakeshore Dr 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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 01/15/25 at 1:50 PM, Surveyor interviewed Director of Nursing (DON) B regarding observation. DON B stated the expectation is for staff to disinfect reusable equipment after every use with a resident and before storing in medication cart. DON B stated that re-education would be completed with nursing staff as this practice puts residents at risk for infection.</p> <p>47807</p> <p>Example 3</p> <p>The facility policy, titled Enhanced Barrier Precautions, dated June 2024, states, 5. EBPs [Enhanced Barrier Precautions] are indicated (When contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical device that placed them at increased risk . 10. Signs are posted in the door or wall outside the resident's room indicating the type of precautions and PPE required.</p> <p>R22 was admitted to the facility on [DATE] and has orders that include:</p> <p>Flush G Tube with 90ml before feeding and 90ml after feeding six times a day for Flush G Tube</p> <p>Active 11/25/2024 16:00</p> <p>Tube feeding and enhanced barrier precautions. Gown and gown when doing any direct cares. Every shift for infection control.</p> <p>active 10/2/2024 15:00</p> <p>On 01/12/25, Surveyor observed resident during initial screening and noted no enhanced barrier precautions indicated on door, or PPE cart outside of door.</p> <p>On 01/13/25 at 10:53 AM, Surveyor observed no signage indicating that R22 was on enhanced barrier precautions or PPE cart outside room.</p> <p>On 01/15/25 at 1:15 PM, Surveyor interviewed Certified Nursing Assistant (CNA) J regarding R22's precautions. CNA J was surprised and was sure that R22 was on enhanced barrier precautions and wondered if the sign got covered. Surveyor and CNA J went to R22's room to locate the enhanced barrier signage, and both Surveyor and CNA did not see the sign.</p> <p>On 01/15/25 at 1:38 PM, Surveyor interviewed Director of Nursing (DON) B regarding expectations for a resident who has an indwelling medical device and the precautions needed by staff. DON B indicated that a resident with a PEG tube would need to be on enhanced barrier precautions. DON B was surprised to learn that R22 did not have enhanced barrier precautions signage or PPE outside of their room. Together Surveyor and DON B went to look at R22's room and could not locate precaution signage or PPE. DON B said they would expect that R22 have both a sign and cart outside of their room. DON B was surprised that they didn't, and it was their belief there was always one there.</p>		