STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525670	A. Building B. Wing	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oconto Health and Rehab Center	101 First St Oconto, WI 54153

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40342 Based on observation and staff and resident interview, the facility did not ensure 3 residents (R) (R1, R7, and R8) of 9 sampled residents had call lights within reach. R1, R7, and R8 were observed in their rooms without a call light within reach or a means to notify staff if assistance was needed. Findings include: On 6/3/24, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] with diagnoses including cerebral infarction with left sided paralysis, below elbow amputation of right arm, and anxiety disorder. R1's Minimum Data Set (MDS) assessment, dated 5/12/24, stated R1's Brief Interview for Mental Status (BIMS) score was 12 out of 15 which indicated R1 had minimal cognitive impairment. R1's medical record indicated R1's Power of Attorney for Healthcare (POAHC) was responsible for R1's healthcare decisions. R1's care plan included the intervention Place call light within reach with no specific instruction regarding what type of call light or placement was needed to accommodate R1's left arm paralysis and right arm below elbow amputation. R1's care plan indicated R1 was dependent on staff for all activities of daily living (ADLs). On 6/3/24, Surveyor reviewed R7's medical record. R7 was admitted to the facility on [DATE] with diagnoses including congestive heart failure and diabetes mellitus. R7's MDS assessment, dated 4/10/24, stated R7's BIMS score was also 12 out of 15. R7's medical record indicated R7 was responsible for R7's healthcare decisions. R7's care plan indicated R7 required staff assistance for most ADLs including toilet use and transfers. On 6/3/24, Surveyor reviewed R8's medical record. R8 was admitted to the facility on [DATE] with diagnoses including chronic pain syndrome and anxiety disorder. R8's MDS assessment, dated 4/30/24, stated R8's BIMS score was 15 out of 15 which indicated R8 had no cognitive impairment. R8's medical record indicated R8 was responsible for R8's healthcare decisions. R8's care plan indicated R8 required staff assistance for most ADLs including toilet use and transfers. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/3/24 at 2:31 PM, Surveyor observed R1 sideways in bed with R1's feet hanging off the mattress and calling out, Where's (person's name)? When Surveyor knocked on the door R1 stated, Nobody wants to help me get out of bed. Surveyor observed a soft-touch call light near R1's left elbow. When Surveyor asked if R1 could activate the call light, R1 stated, I don't know where it is. Surveyor indicated the call light was near R1's left arm. R1 stated, I can't use my left arm. Surveyor located staff who entered R1's room and assisted R1 into R1's wheelchair. On 6/3/24 at 2:55 PM, R7 called to Surveyor from R7's room as Surveyor passed by in the hallway. R7 asked if Surveyor could give R7 the call light which was observed on R7's bed. R7 was in a chair approximately three to four feet away from the bed and was unable to reach the call light. On 6/3/24 at 3:00 PM, Surveyor observed R8's call light on R8's bed with R8's bedside table between R8 and the bed. When Surveyor asked if R8 could reach call light, R8 stated R8 could not reach the call light. On 6/3/24 at 3:18 PM, Surveyor observed R1 in a wheelchair next to R1's bed. R1 was repeating, Can someone cover me up with my jacket? R1's call light was observed on R1's lower chest near R1's left elbow. On 6/3/24 at 3:19 PM, Surveyor and Director of Nursing (DON)-B entered R1's room. When asked if R1's call light was placed properly to accommodate R1's needs, DON-B stated the call light on R1's chest was okay. DON-B stated R1 could activate the call light with the stump of R1's right arm. When Surveyor asked R1 to activate the call light, R1 stated, I don't know where it is. When DON-B stated the call light was on R1's chest, R1 placed the stump of R1's right arm on R1's upper right chest. When Surveyor asked if that was where R1 preferred R1's call light to be, R1 indicated that was correct. R1 felt around R1's chest until R1 reached edge of the call light and activated it. Surveyor verified the call light was functioning. DON-B offered R1 a blanket and moved R1's call light to R1's upper right chest. DON-B verified R1's care plan did not indicate R1's need for a soft-touch call light or need for specific placement of the call light.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40342 Based on observation, staff interview, and record review, the facility did not ensure the accurate administration of medication for 1 resident (R) (R1) of 9 sampled residents. In addition, the facility did not provide pharmaceutical services to ensure the safe handling of drugs and biologicals for 1 (R9) of 11 residents observed during medication administration. R1 did not receive multiple doses of hydrocortisone (a steroid medication) as ordered by R1's physician. During medication pass on [DATE], Surveyor noted slot 2 of R9's second card of buspirone (used to treat anxiety) contained a half pill that was taped in the slot. In addition, Surveyor observed Registered Nurse (RN)-C destroy a half tablet of buspirone by discarding it in the garbage. Findings include: The facility's undated Medication Administration policy indicates: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice. The facility's Destruction of Unused Drugs Policy, with a copyright date of 2024, indicates: All unused, contaminated or expired prescription drugs shall be disposed of in accordance with state laws and regulations .1. Drugs will be destroyed in a manner that renders the drugs unfit for human consumption and disposed of in compliance with all current and applicable state and federal requirements. 2. Unused, unwanted, and non-returnable medications should be removed from their storage area and secured until destroyed. 1. On [DATE], Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] with diagnoses including cerebral infarction (stroke) with left-sided paralysis, below elbow amputation of right arm, and anxiety disorder. R1's Minimum Data Set (MDS) assessment, dated [DATE], stated R1's Brief Interview for Mental Status (BIMS) score was 12 out of 15 which indicated R1 had minimal cognitive impairment. R1's medical record indicated R1's Power of Attorney for Healthcare (POAHC) was responsible for R1's healthcare decisions. R1's medical record indicated R1 was readmitted to the facility following a hospital stay on [DATE] and had an allergy to cortisone (a drug related to hydrocortisone). R1's medical record did not indicate the type of reaction R1 had to cortisone in the past. A hospital discharge summary, dated [DATE], stated, .Medication changes .Take tablet hydrocortisone 10 mg (milligrams) in the morning, 5 mg in the evening and 5 mg at night . A nurse progress note, dated [DATE], indicated the writer sent a message to the physician that indicated R1 had an allergy to hydrocortisone and to please clarify the order. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nurse progress note, also dated [DATE], indicated: Per Nurse Practitioner (NP), have physician clarify medication orders during physician's visit tomorrow. The note instructed staff to hold R1's hydrocortisone until the physician's visit. The NP indicated R1 received hydrocortisone in the hospital with no adverse reaction and R1 may not have a true allergy to hydrocortisone. A physician visit note, dated [DATE], did not mention or address the hospital order for hydrocortisone. An Endocrinology physician visit note, dated [DATE], stated, .Continue hydrocortisone 10 mg after breakfast, 5 mg after supper . A nurse progress note, dated [DATE], indicated to continue with hydrocortisone 10 mg after breakfast and 5 mg after dinner per Endocrinology. R1's medication administration record (MAR) indicated the facility did not start administering hydrocortisone to R1 until the breakfast dose on [DATE]. On [DATE] at 12:59 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated DON-B found R1's Endocrinology note buried on the nurses' station desk on [DATE]. DON-B stated staff should have followed-up with R1's physician when R1's physician did not address the hydrocortisone allergy question on [DATE]. DON-B verified R1's orders from the [DATE] Endocrinology visit should have been processed on [DATE]. On [DATE] at 2:35 PM, Surveyor interviewed DON-B who indicated the facility had not yet educated all nurses regarding timely transcription and clarification of physician orders. DON-B stated staff were provided informal undocumented education about not passing off work onto the next nurse. 2. On [DATE], Surveyor reviewed R9's medical record. R9 was admitted to the facility on [DATE] with diagnoses including bipolar disorder and unspecified mental disorder to unknown physiological condition. R9's MDS assessment, dated [DATE], indicated R9 also had a BIMS score of 12 out of 15. R9 had an order, dated [DATE], for buspirone HCL oral tablet 15 mg give 1 tablet by mouth three times a day for anxiety. During an observation of medication administration on [DATE] at 12:53 PM, Surveyor observed RN-C discard a half tablet of buspirone in the garbage on the medication cart after RN-C cut a whole tablet in half. Pharmacy sent the facility two medication cards with 10 mg per card. Staff needed to cut one 10 mg tablet in half to obtain the prescribed dose of 15 mg. Surveyor also noted slot 2 of R9's second card of buspirone contained a half pill that was taped in the slot. RN-C verified a half pill was taped in the slot and stated RN-C did not use the half pill because RN-C did not split the pill and couldn't verify if the medication was buspirone. At the time of the disposal, Surveyor asked RN-C if the garbage on the medication cart is where RN-C should dispose of medication. RN-C stated yes. When Surveyor asked RN-C if wasted medication should be put in the Drugbuster (solution that dissolves medications safely) or a similar drug disposal system, RN-C indicated the medication should have been put in the Drugbuster and not the garbage.