

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525670	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2024
NAME OF PROVIDER OR SUPPLIER Oconto Health and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0567</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to manage his or her financial affairs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45942</p> <p>Based on resident and staff interview and record review, the facility did not allow 1 resident (R) (R2) of 3 sampled residents to set up a petty cash fund or Resident Fund Management Service (RFMS) account.</p> <p>R2's Corporate Guardian (CG)-H asked the facility to set up a resident account for R2. CG-H was told an account could not be set up and the facility could not cash checks for R2 unless CG-H provided direct deposit account information.</p> <p>Findings include:</p> <p>The facility's Resident Personal Funds policy, revised 7/4/24, indicates: .2) If the resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility. Deposit of Funds: .3) Residents whose care is funded by Medicaid; the facility will deposit the residents' personal funds in excess of \$50 in an interest-bearing account separate from any of the facility's operating accounts, and that credits all interest earned on residents' funds to that account .4) The facility will maintain personal funds that do not exceed \$50 in a non-interest bearing account, or petty cash fund.</p> <p>On 11/22/24, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] with diagnoses including dementia, schizophrenia, and anxiety. R2's Minimum Data Set (MDS) assessment, dated 8/27/24, had a Brief Interview for Mental Status (BIMS) score of 3 out of 15 which indicated R2 had severely impaired cognition. R2 had a corporate guardian.</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: 525670	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2024
NAME OF PROVIDER OR SUPPLIER Oconto Health and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0567</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 11/22/24 at 9:11 AM, Surveyor interviewed Business Office Manager (BOM)-E regarding the facility's RFMS. BOM-E indicated a resident's name is entered in the system and the resident or their representative sign documentation that gives approval for the facility to establish an account via direct deposit. BOM-E indicated residents and/or their representatives can also provide cash, checks, and money orders that BOM-E can put in the account. BOM-E indicated the facility accepts corporate guardian accounts and verified BOM-E and Social Worker (SW)-F had been in contact with CG-H. BOM-E verified R2 had asked about money and indicated R2 did not have an account because CG-H had not been responsive to R2's needs. BOM-E indicated the facility was unable to open an account for R2 because CG-H stated the guardianship organization could not give out bank account information for direct deposit. BOM-E verified CG-H had sent two fifty dollar checks to the facility for R2. BOM-E stated the facility could not process the checks because CG-H had not signed the facility's RFMS authorization agreement. BOM-E indicated an account could be established for R2 if CG-H responded appropriately and indicated the facility could not open an account for R2 from the documentation. BOM-E confirmed both checks were returned to CG-H.</p> <p>On 11/22/24 at 11:49 AM, Surveyor interviewed BOM-E who indicated the facility could not set up an account that did not require an automatic transfer. BOM-E indicated once the account was established, the facility had the legal authority to cash checks, however, the facility could not cash checks until that time.</p> <p>On 11/22/24 at 12:49 PM, Surveyor interviewed BOM-E who confirmed the facility did not have a process to receive checks/cash and create petty cash accounts for residents. BOM-E indicated it was not the facility's responsibility and was up to the guardian. BOM-E indicated a petty cash account was available if a direct deposit account was established by the guardian. BOM-E indicated the facility cannot manage all residents' finances without any type of legality and would be unable to manage petty cash accounts for multiple residents. BOM-E was not sure how R2 could have access to money and indicated the only thing the facility could do was provide the RFMS form for CG-H to sign.</p> <p>On 11/22/24 at 1:05 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who asked how the facility could track R2's petty cash account if R2 didn't already have a bank account. NHA-A verified the facility had a petty cash tracking process and indicated NHA-A was new and still learning. NHA-A verified if residents ask the facility to handle funds, the facility should handle their funds.</p> <p>On 11/22/24 at 1:51 PM, Surveyor interviewed R2 who indicated R2 wanted to be like everybody else and be able to buy things, including soda. R2 indicated R2 did not know how to obtain an account but would like to have one. R2 also stated R2 had no other money and would like if the facility could help R2 establish an account.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525670	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2024
NAME OF PROVIDER OR SUPPLIER Oconto Health and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40342</p> <p>Based on observation, staff interview, and record review, the facility did not ensure services were provided to prevent further decrease in range of motion for 1 resident (R) (R1) of 8 sampled residents.</p> <p>R1's plan of care did not contain interventions to address R1's contracted left hand.</p> <p>Findings include:</p> <p>On 11/22/24, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including diabetes mellitus, amputation of right hand, and hemiplegia (paralysis/immobility of one side of the body) following cerebral infarction (also known as stroke) affecting the left side. R1's Minimum Data Set (MDS) assessment, dated 10/26/24, indicated R1 was rarely/never understood. R1's medical record indicated R1 had a Power of Attorney for Healthcare (POAHC) who was responsible for R1's healthcare decisions.</p> <p>On 11/22/24 at 9:11 AM, Surveyor observed R1 in bed. Surveyor noted R1 had a below-the-elbow amputation of the right arm and R1's left hand/fingers were contracted and contained a rolled up wash cloth.</p> <p>On 11/22/24, Surveyor reviewed R1's care plan which did not address R1's left hand contracture.</p> <p>On 11/22/24 at 2:47 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who verified R1's care plan did not address R1's left hand contracture. NHA-A indicated the facility's MDS nurse had been working on it. NHA-A indicated R1 used to be able to open R1's left had a little bit. NHA-A indicated therapy staff were going to find a piece of foam to place in R1's left hand and staff were using a wash cloth in the meantime. NHA-A verified R1's care plan should have included interventions to prevent R1's left hand contracture from worsening.</p> <p>On 11/26/24, Hospice RN (HRN)-G returned Surveyor's call from 11/22/24. On 11/26/24 at 8:15 AM, Surveyor interviewed HRN-G who verified HRN-G was R1's primary Hospice nurse. HRN-G indicated a Hospice Certified Nursing Assistant (CNA) who was assigned to R1 updated HRN-G during the first week of November (2024) that the Hospice CNA had to clean green slime out of the palm of R1's left hand and that the odor from R1's left hand was stinky. HRN-G indicated HRN-G assessed R1's hand after the Hospice CNA provided care and found no redness or open wound. HRN-G placed a wash cloth in R1's left hand. HRN-G indicated HRN-G informed facility staff of the Hospice CNA's report at a care conference held on 11/13/24.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525670	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2024
NAME OF PROVIDER OR SUPPLIER Oconto Health and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40342</p> <p>Based on observation, staff interview, and record review, the facility did not consistently monitor nutrition/hydration intake for 1 resident (R) (R1) of 3 sampled residents.</p> <p>R1 had orders for one-on-one feeding assistance and meal and fluid intake to be documented each meal. Staff did not consistently document those items. In addition, R1's care plan was not updated with an intervention for staff to offer and provide R1 water every hour.</p> <p>Findings include:</p> <p>On 11/22/24, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including diabetes mellitus, amputation of right hand, and hemiplegia (paralysis/immobility of one side of the body) following cerebral infarction (also known as stroke) affecting the left side. R1's Minimum Data Set (MDS) assessment, dated 10/26/24, indicated R1 was rarely/never understood. R1's medical record indicated R1 had a Power of Attorney for Healthcare (POAHC) who was responsible for R1's healthcare decisions.</p> <p>R1's medical record indicated R1 weighed 183.5 pounds (lbs) on 5/7/24. On 11/7/24, R1 weighed 156.5 lbs which was a 14.71 % weight loss.</p> <p>R1's care plan indicated R1 required total assistance with eating and contained an intervention, dated 8/20/24, to offer fluids to R1 frequently.</p> <p>On 11/22/24 at 9:11 AM, Surveyor observed R1 in bed and noted R1 had a below-the-elbow amputation of the right arm and a flaccid (soft and limp) left arm/hand.</p> <p>On 11/22/24, Surveyor reviewed a Grievance Report, dated 11/7/24, that indicated a Certified Nursing Assistant (CNA) brought a supper tray to R1's room. The Grievance report indicated the CNA returned 37 minutes later to feed R1 but just took the tray. The Grievance investigation indicated the facility educated staff on 11/8/24 and 11/14/24 to make sure R1 was fed even when family was present and to provide R1 with water every hour. The education forms contained a total of four different CNA signatures (two CNAs signed twice between the two dates).</p> <p>R1's medical record contained a note, dated 9/18/24, that indicated R1 was seen by Medical Director (MD)-C who indicated R1 should be one-on-one for meals to increase intake, should be evaluated and treated by the Registered Dietitian (RD) for a 10 lb weight loss, and staff should record R1's intakes.</p> <p>R1's medical record contained an RD note, dated 9/19/24, that indicated R1 triggered for significant weight loss, had orders for one-on-one for meals to monitor intake, and had no swallowing or chewing issues. In addition to other interventions, the RD recommended R1's supplement shake be increased from twice daily to three times daily to promote calorie intake. The RD also indicated staff should honor R1's food preferences whenever medically possible to maximize acceptance.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525670	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2024
NAME OF PROVIDER OR SUPPLIER Oconto Health and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Surveyor reviewed R1's September, October and November (2024) Treatment Administration Records (TARS) which contained orders for one-on-one for meals and record intake three times a day (effective 9/19/24). Surveyor noted there were two missing entries in September, six missing entries in October, and three missing entries in November.</p> <p>On 11/22/24 at 12:28 PM, Surveyor interviewed MD-C via phone. MD-C verified MD-C was the facility's Medical Director and R1's physician. MD-C indicated R1's order for one-on-one for meals was prompted by R1's family's concern of poor oral intake as well as R1's weight loss. MD-C indicated R1 was not able to consistently use R1's extremities.</p> <p>Surveyor reviewed CNA documentation of R1's fluid intake on each shift for September, October and November (2024). Surveyor noted there were 33 missing entries in September, 56 missing entries in October, and 25 missing entries in November.</p> <p>On 11/22/24 at 2:33 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated NHA-A expects CNAs to document fluid intake every shift. NHA-A indicated the missing documentation meant R1 didn't receive anything and NHA-A could not prove R1 received fluids during those shifts.</p> <p>On 11/22/24 at 2:47 PM, Surveyor interviewed NHA-A who indicated staff should offer R1 something to drink, preferably water, at least once per hour. NHA-A verified R1's care plan did not indicate R1 should be offered/provided water every hour. When Surveyor indicated there were only four CNA signatures on the facility's education, NHA-A indicated the facility only had five CNA employees and used multiple agency CNAs. NHA-A verified if interventions were not on a resident's care plan, staff (including agency staff) would not know to complete the task.</p> <p>On 11/22/24 at 2:49 PM, Surveyor interviewed CNA-D who indicated R1 required staff assistance for meals and fluid intake as well as all other activities of daily living (ADLs). CNA-D indicated CNA-D was not aware that R1 should be offered fluid at least every hour.</p>		