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	02/12/2025

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

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43361 Based on staff and resident representative interview and record review, the facility did not ensure a physician and Guardian were notified of medication refusals for 1 resident (R) (R3) of 11 sampled residents. R3 refused multiple medications in January and February of 2025. The facility did not notify R3's physician or Guardian. Findings include: The facility's Medication Administration policy, dated 1/2024, indicates: .2. If a dose of regularly scheduled medication is withheld, refused, or given at other than the scheduled time .If two consecutive doses of a vital medication are withheld or refused, the physician is notified. On 2/12/25, Surveyor reviewed R3's medical record. R3 was admitted to the facility on [DATE] and had diagnoses including diabetes mellitus type 2, hypertension, obsessive compulsive disorder (OCD), depression, disruptive mood dysregulation disorder, personality disorder, and dysphagia (difficulty swallowing). R3's Minimum Data Set (MDS) assessment, dated 12/16/24, had a Brief Interview for Mental Status (BIMS) score of 9 out of 15 which indicated R3 had moderately impaired cognition. R3 had a corporate Guardian for decision making. R3's medical record indicated R3 was prescribed the following medications and refused the following medications at least twice in a row without physician notification: Aspirin 81 milligram (mg) chewable tablet once daily for heart health ~Refused 1/2/25, 1/3/25, 1/12/25, 1/13/25, 1/14/25, 1/17/25, and 1/18/25 Atorvastatin 10 mg once daily for hypertension ~Refused 1/26/25, 1/27/25, 2/5/25, 2/6/25, 2/8/25, and 2/9/25 Divalproex Sodium Extended Release 24 hour 500 mg (4 tablets) once daily for OCD ~Refused 1/26/25, 1/27/25, 2/5/25, 2/6/25, 2/8/25, and 2/9/25 (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Fluoxetine HCL 20 mg once daily for depression ~Refused 1/2/25, 1/3/25, 1/12/25, 1/13/25, 1/14/25, 1/17/25, and 1/18/25 Hydrochorothiazide 12.5 mg once daily for hypertension ~Refused 1/2/25, 1/3/25, 1/12/25, 1/13/25, 1/14/25, 1/17/25, and 1/18/25 Hydroxyzine 25 mg in AM and 12.5 mg in PM once daily for personality disorder ~Refused (PM dose) 1/26/25, 1/27/25, 2/5/25, 2/6/25, 2/8/25, and 2/9/25 ~Refused (AM dose) 1/2/25, 1/3/25, 1/12/25, 1/13/25, 1/14/25, 1/17/25, and 1/18/25 Losartan 100 mg once daily for hypertension ~Refused 1/2/25, 1/3/25, 1/4/25, 1/12/25, 1/13/25, 1/14/25, 1/17/25, and 1/18/25 Norvasc 10 mg once daily for hypertension ~Refused 1/2/25, 1/3/25, 1/4/25, 1/12/25, 1/13/25, 1/14/25, 1/17/25, and 1/18/25 Pantoprazole 40 mg once daily for gastroesophageal reflux disease (GERD) ~Refused 1/2/25, 1/3/25, 1/4/25, 1/12/25, 1/13/25, 1/14/25, 1/17/25, and 1/18/25 Potassium oral tablet once daily for hypokalemia ~Refused 1/2/25, 1/3/25, 1/4/25, 1/12/25, 1/13/25, 1/14/25, 1/17/25, and 1/18/25 Risperidone 1 mg in AM and 2 mg in PM once daily for personality disorder ~Refused AM dose 1/2/25, 1/3/25, 1/4/25, 1/12/25, 1/13/25, 1/14/25, 1/17/25, and 1/18/25 ~Refused PM dose 1/5/25, 1/6/25, 1/8/25, 1/9/25, 1/26/25, and 1/27/25 Metformin 500 mg twice daily for diabetes mellitus type 2 ~Refused AM dose 1/2/25, 1/3/25, 1/4/25, 1/12/25, 1/13/25, 1/14/25, 1/17/25, and 1/18/25 R3's medical record did not include physician or Guardian notification for R3's medication refusals. On 2/12/25 at 12:31 PM, Surveyor interviewed R3's Guardian ((GD)-D) who was not aware R3 had been refusing medication and indicated medication refusals were not discussed at R3's care conference on 2/4/25. (continued on next page)

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/12/25 at 2:30 PM, Surveyor interviewed Director of Nursing (DON)-B who verified staff should have contacted R3's physician regarding R3's medication refusals. DON-B indicated notification should occur after 3 medication refusals.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43361 Based on observation, staff and resident representative interview, and record review, the facility did not provide treatment and services to prevent weight loss and hydration for 2 residents (R) (R3 and R1) of 11 sampled residents. R3 had an order for a mechanical soft diet with ground meat. On 12/20/24, a swallow study and speech therapy evaluation was requested for a possible diet upgrade. On 12/30/24, Speech Therapy (ST) upgraded R3's diet, however, R3's diet order was not changed. As of 2/12/25, the swallow study was not completed. In addition, R3's meal intakes were not consistently documented. R1 was at risk for dehydration. Staff did not consistently document or monitor R1's fluid intake to determine if hydration interventions were effective. Findings include: The facility's Nutritional Management policy, dated 4/9/24, indicates: The facility provides care and services to each resident to ensure the resident maintains acceptable parameters of nutritional status in the context of his or her overall condition. 2. Identification/Assessment .IV. Food and fluid intake. The facility's Hydration (Food/Fluid) Monitoring policy, dated 10/30/24, indicates: .6. Record beverage intake in designated locations. 1. On 2/12/25, Surveyor reviewed R3's medical record. R3 was admitted to the facility on [DATE] and had diagnoses including visual loss both eyes, unspecified sensorineural hearing loss, moderate intellectual disability, obsessive compulsive disorder (OCD), disruptive mood dysregulation disorder, personality disorder, and dysphagia (difficulty swallowing). R3's Minimum Data Set (MDS) assessment, dated 12/16/24, had a Brief Interview for Mental Status (BIMS) score of 9 out of 15 which indicated R3 had moderately impaired cognition. R3 had a corporate Guardian for decision making. R3's medical record indicated R3's admission weight on 11/5/24 was 169.4 pounds (lbs). Upon admission, R3 had an order for a mechanical soft diet with ground meat. R3's last weight on 1/22/25 was 158.4 lbs. A quarterly assessment, dated 2/4/25, indicated R3 had a 7.3% weight loss in 3 months. (A significant weight loss is considered 7.5% in 3 months.) Surveyor reviewed R3's meal intakes for January and February of 2025 and noted approximately 20% of R3's intakes were not documented in January and approximately 33% of R3's intakes were not documented in February. The intakes that were documented noted the percentage of the meal that R3 ate or if R3 refused the meal. Communication to R3's physician on 12/20/24 indicated R3 had an order for a regular mechanical soft diet with ground meat. R3 did not like ground meat and requested regular food. An order/referral for a swallow study was requested to see if R3's diet could be upgraded. A Nurse Practitioner (NP) gave an order for a ST evaluation for a potential diet upgrade from ground meat. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/30/24, ST evaluated R3 and recommended a mechanical soft diet with cut up meat. A progress note, dated 2/4/25, indicated R3's family expressed concern at a care conference that R3 had lost weight and was not receiving meals. Registered Dietitian (RD)-F was aware of R3's weight loss. Director of Nursing (DON)-B was awaiting a response regarding starting a house supplement. The note indicated R3 refused meals at times and staff offered alternatives. R3's family was not aware R3 was on a mechanical soft diet. The team discussed asking R3's physician to order a swallow study to see if R3's swallowing issues had resolved and if R3's diet could be upgraded. On 2/12/25 at 11:50 AM, Surveyor observed staff deliver a meal tray to R3's room. R3's meal ticket indicated R3 should receive a mechanical soft diet with ground meat. Surveyor noted R3's tray contained ground meat with gravy. R3 refused lunch and indicated to staff that R3 had a big breakfast. On 2/12/25 at 12:31 PM, Surveyor interviewed R3's Guardian ((GD)-D) who indicated R3 was supposed to have a swallow study as indicated during R3's care conference on 2/4/25. GD-D had not heard if a swallow study was scheduled. GD-D also did not know R3 was prescribed a diet with ground meat. GD-D indicated R3 ate a regular diet prior to getting sick and GD-D thought the ground meat order originated when R3 was in the hospital. GD-D indicated a family member bought R3 a hamburger which R3 ate with no concerns. GD-D indicated R3 should be upgraded to a regular diet so R3 will want to eat and not lose weight. On 2/12/25 at 12:45 PM, Surveyor interviewed Speech Therapist (ST)-E who saw R3 on two occasions upon admission. ST-E received a referral in mid-December to see if R3's diet could be upgraded. ST-E saw R3 on 12/30/24 and recommended an upgrade from ground meat to cut up meat. ST-E filled out a physician order form with the recommendation. The form, dated 12/30/24, contained a diet clarification order for a mechanical soft diet with cut up meat. ST-E indicated ST-E sent a copy of the form to R3's nurse and the kitchen. ST-E indicated ST-E received a referral that morning (2/12/25) to evaluate R3 for a diet upgrade but thought ST-E evaluated R3 a month and a half ago. When asked about the swallow study, ST-E stated swallow studies go through the physician and the resident is scheduled for an outside appointment. On 2/12/25 at 1:14 PM, Surveyor interviewed RD-F who indicated RD-F completed R3's quarterly evaluation and noted R3 was close to a significant weight loss since admission. RD-F requested that R3 start a supplement. RD-F was not aware that R3 was evaluated on 12/30/24 by ST and that ST had requested a diet upgrade. When asked if RD-F was aware that swallow studies were requested to see if R3's diet could be upgraded, RD-F stated RD-F was not aware. When informed that R3's intakes were not documented consistently, RD-F confirmed staff should document intakes for each meal because RD-F uses the documentation for assessments. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/12/25 at 2:30 PM, Surveyor interviewed DON-B who reviewed the communication to the physician in December regarding a diet upgrade for R3. DON-B indicated a swallow study was not scheduled. DON-B indicated staff notified R3's physician after a care conference on 2/4/25 and requested an ST evaluation and swallow study. DON-B indicated the physician replied to have ST evaluate R3 but did not address the swallow study. DON-B indicated staff who received the reply should have contacted the physician directly to address the swallow study. DON-B reviewed the request on 12/20/24 and verified the physician ordered an ST evaluation for R3 but did not address the swallow study then either. DON-B was not aware ST saw R3 on 12/30/24 and recommended a diet upgrade. DON-B indicated R3's new diet order should have been implemented. DON-B also indicated staff should document meal intakes for all residents' meals. 40342 2. On 2/12/25, 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 MDS assessment, dated 1/25/25, 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. R1's care plan indicated R1 required total assistance with eating. R1's care plan also indicated R1 had dehydration and a potential for fluid deficit and contained an intervention (dated 11/22/24) to offer fluids to R1 hourly. On 2/12/25, Surveyor observed staff offer and provide R1 with fluids on an hourly basis On 2/12/25, Surveyor reviewed Certified Nursing Assistant (CNA) documentation of R1's fluid intake each shift from 1/1/25 through 2/11/25. R1's medical record indicated R1 was hospitalized for three days in January. Of the 118 shift opportunities for documentation, 67 shifts had missing fluid intake documentation which indicated 56.78% of shifts were missing documentation. On 2/12/25 at 1:49 PM, Surveyor interviewed DON-B who indicated staff should offer fluids to R1 every 30 minutes to an hour. DON-B indicated R1 usually accepts fluids when offered. DON-B indicated CNAs are expected to document R1's fluid intake every shift and nurses are expected to ensure the documentation is completed timely. DON-B verified the missing documentation indicated above and stated, Makes it look like (R1) is not getting the fluid (R1) needs.

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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** 51043 Based on observation, staff interview, and record review, the facility did not provide pharmaceutical services to meet the needs of 2 residents (R) (R5 and R6) of 4 sampled residents. R5 did not receive calcium 200 milligrams (mg) as ordered during the AM medication pass on 2/12/25. In addition, staff did not update R5's physician regarding the missed medication. R6 did not receive Seroquel XR 50 mg as ordered during the AM medication pass on 2/12/25. Findings include: The facility's Medication Administration Policy, revised 11/12/24, indicates: .10. Ensure that the six rights of medication administration are followed .b. Right drug .11. Review Medication Administration Record (MAR) to identify medication to be administered .22. If medication is unable to be administered due to the unavailability of the medication, notify the pharmacy to obtain alternative medication options, to include contingency availability, and consult with the physician . 1. On 2/12/25, Surveyor reviewed R5's medical record. R5 was admitted to the facility on [DATE] and had diagnoses including disorder of bone, pulmonary fibrosis (a serious lung disease that makes it hard for the lungs to function normally), chronic systolic heart failure, and bipolar disorder. A Minimum Data Set (MDS) assessment had not yet been completed for R5. R5 was responsible for R5's medical decisions. On 2/12/25 at 8:34 AM, Surveyor observed Licensed Practical Nurse (LPN)-C administer R5's medication. R5's AM medications included calcium 200 mg once daily (supplement). LPN-C indicated the calcium was not in the medication cart. LPN-C checked other areas in the facility and indicated the facility was out of calcium 200 mg. LPN-C updated the staff who ordered medication and marked the calcium as not administered. LPN-C did not notify R5's physician. On 2/12/25 at 12:21 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated LPN-C should have followed the facility's Medication Administration Policy and updated the physician that R5's calcium 200 mg was not administered because it was not available. 2. On 2/12/25, Surveyor reviewed R6's medical record. R6 was admitted to the facility on [DATE] and had diagnoses including Hirschsprung disease (a rare birth defect that prevents stool from moving normally through the large intestine), chronic obstructive pulmonary disease (COPD), anxiety, depression, and schizoaffective disorder. An MDS assessment had not yet been completed for R6. R6 was responsible for R6's medical decisions. On 2/12/25 at 9:03 AM, Surveyor observed LPN-C administer R6's medication. LPN-C indicated there was no Seroquel in the medication cart for R6. LPN-C removed quetiapine (generic equivalent of Seroquel) from the facility's contingency stock and administered the medication to R6. LPN-C showed the medication to Surveyor which was quetiapine 25 mg. LPN-C indicated LPN-C gave two 25 mg tablets to R6 which equaled the 50 mg dose that was ordered. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/12/25 at approximately 10:00 AM, Surveyor reviewed R6's medical record and noted R6 had an order for Seroquel XR (extended release) 50 mg give 1 tablet by mouth once daily for schizoaffective disorder. On 2/12/25 at approximately 11:30 AM, Surveyor interviewed LPN-C who indicated the quetiapine that LPN-C administered to R6 was not extended release. LPN-C indicated LPN-C would update the physician regarding the medication error. On 2/12/25 at 12:21 PM, Surveyor interviewed DON-B who indicated LPN-C administered an incorrect medication to R6 which resulted in a medication error.