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 03/25/2026
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)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not report allegations of abuse and exploitation to the State Agency (SA) for 1 resident (R) (R4) of 1 sampled resident.R4 informed staff on 2/6/26 that Certified Nursing Assistant (CNA)-C stated R4 could not get out of bed for a limited amount of time. R4 also reported that CNA-C accepted a gift from R4. The allegations of abuse and exploitation were not reported to the SA. Findings include:The facility's Abuse, Neglect and Exploitation policy, revised 7/1/25, indicates: It is the guideline of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property .The facility will have written procedures that include: Reporting of all alleged violations to the Administrator, State Agency, Adult Protective Services, and to all other required agencies within specified timeframes: Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.From 3/24/26 to 3/25/26, Surveyor reviewed R4's medical record. R4 was admitted to the facility on [DATE] and had diagnoses including drug-induced adrenocortical insufficiency, rheumatoid arthritis, anxiety, and depression. R4's Minimum Data Set (MDS) assessment, dated 2/14/26, had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated R4 had intact cognition.Surveyor reviewed the facility's grievance file and noted R4 filed a grievance with the facility on 2/6/26. The grievance indicated R4 asked if staff could transfer R4 into R4's wheelchair but was told R4 could not get up if R4 only wanted to be up for an hour. The grievance was reviewed by Director of Nursing (DON)-B. The summary of findings indicated R4 requested to get up but changed R4's mind due to the duration of time R4 would have to be in the wheelchair.On 3/24/26 at 12:32 PM, Surveyor interviewed DON-B who verified R4 reported to staff on 2/6/26 that CNA-C refused to get R4 into R4's wheelchair during an overnight shift if R4 only wanted be up for an hour. DON-B spoke with CNA-C who indicated CNA-C told R4 CNA-C would assist R4 into the wheelchair, however, CNA-C might be unable to get R4 out of the wheelchair in an hour if CNA-C was assisting other residents. CNA-C indicated CNA-C would assist R4 as soon as possible. R4 chose not to transfer into the wheelchair at that time. On 3/25/26 at 1:00 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A and DON-B regarding reporting allegations of abuse to the SA. NHA-A and DON-B confirmed allegations of abuse should be reported to the SA.2. A progress note, dated 2/11/26 by Social Worker Designee (SWD)-D, indicated R4 spoke with attorneys who advised R4 to share with the facility that R4 gave CNA-C a tumbler as a gift. The note indicated R4 knew R4 was not supposed to give gifts to staff but wanted to do something nice for CNA-C.On 3/24/26 at 12:32 PM, Surveyor interviewed DON-B who indicated R4 informed DON-B on 2/6/26 that R4 purchased a mug for CNA-C who refused to accept the mug on multiple occasions but finally accepted it due to pressure from R4. On 3/25/26 at 1:00 PM, Surveyor interviewed NHA-A and DON-B regarding reporting allegations of exploitation to the SA. NHA-A and DON-B confirmed allegations of exploitation should be reported to the SA.

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 03/25/2026
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)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not thoroughly investigate allegations of abuse and exploitation for 1 resident (R) (R4) of 1 sampled resident.R4 informed staff on 2/6/26 that Certified Nursing Assistant (CNA)-C stated R4 could not get out of bed for a limited amount of time. R4 also reported that CNA-C accepted a gift from R4. The allegations of abuse and exploitation were not thoroughly investigated. Findings include:The facility's Abuse, Neglect and Exploitation policy, revised 7/1/25, indicates: It is the guideline of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property .An immediate investigation is warranted when suspicion of abuse, neglect, or exploitation, or reports of abuse, neglect, or exploitation occur.From 3/24/26 to 3/25/26, Surveyor reviewed R4's medical record. R4 was admitted to the facility on [DATE] and had diagnoses including drug-induced adrenocortical insufficiency, rheumatoid arthritis, anxiety, and depression. R4's Minimum Data Set (MDS) assessment, dated 2/14/26, had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated R4 had intact cognition.1. Surveyor reviewed the facility's grievance file and noted R4 filed a grievance with the facility on 2/6/26. The grievance indicated R4 asked staff to transfer R4 into R4's wheelchair but was told R4 could not get up if R4 only wanted to be up for an hour. The grievance was reviewed by Director of Nursing (DON)-B. The summary of findings indicated R4 requested to get up but changed R4's mind due to duration of time R4 had to be in the wheelchair. The summary of actions indicated staff were educated on residents' rights to choose when they want to be up and out of bed. The grievance did not indicate other residents and staff were interviewed to determine if other residents had similar experiences. In addition, CNA-C was not removed from resident care pending the outcome of the investigation.On 3/24/26 at 12:32 PM, Surveyor interviewed DON-B who verified R4 reported on 2/6/26 that CNA-C refused to transfer R4 into R4's wheelchair during an overnight shift if R4 only wanted to be up for an hour. DON-B indicated CNA-C told R4 that CNA-C would assist R4 into the wheelchair, however, CNA-C might be unable to get R4 out of the wheelchair in exactly an hour if CNA-C was assisting other residents. CNA-C indicated CNA-C would assist R4 as soon as possible. R4 chose not to transfer into the wheelchair at that time. On 3/25/26 at 1:00 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A and DON-B who indicated allegations of abuse should be reported to the State Agency (SA) and thoroughly investigated. NHA-A and DON-B agreed a more thorough investigation could have been completed.2. A progress note, written by Social Worker Designee (SWD)-D and dated 2/11/26, indicated R4 spoke with attorneys who advised R4 to tell the facility R4 gave CNA-C a tumbler as a gift. R4 knew R4 was not supposed to give gifts to staff but wanted to do something nice for CNA-C.On 3/24/26 at 12:32 PM, Surveyor interviewed DON-B who verified R4 informed DON-B on 2/6/26 that R4 purchased a mug for CNA-C which CNA-C refused to accept on multiple occasions but ultimately accepted due to pressure from R4. DON-B stated DON-B spoke to CNA-C who returned the mug. DON-B provided proof that all staff were educated on customer service and not to accept gifts from residents. The facility did not provide evidence that other residents and staff were interviewed to determine if other gifts were given and accepted. On 3/25/26 at 1:00 PM, Surveyor interviewed NHA-A and DON-B regarding thoroughly investigating the allegation of exploitation. NHA-A and DON-B agreed a more thorough investigation could have been completed.

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 03/25/2026
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)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff and resident interview, and record review, the facility did not ensure continuous positive airway ressure (CPAP) machines were cleaned for 3 residents (R) (R1, R2, and R3) of 3 sampled residents. R1, R2, and R3 used a CPAP machines for obstructive sleep apnea (a potentially serious sleep disorder in which breathing repeatedly stops and starts). Staff did not clean the CPAP machines per medical orders and facility policy. Findings include: The facility's CPAP/BiPAP Cleaning policy, revised 6/11/25 indicates: It is the expectation of this facility to clean CPAP/bilevel positive airway pressure (BiPAP) equipment in accordance with current Centers for Disease Control and Prevention (CDC) guidelines and manufacturer's recommendations in order to prevent the occurrence or spread of infection .6. Clean mask frame daily after use with CPAP cleaning wipe or soap and water. Dry well. Cover with plastic bag or completely enclosed in machine storage when not in use . 1. On 3/24/26, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including paraplegia and obstructive sleep apnea. R1's Minimum Data Set (MDS) assessment, dated 1/2/26, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R1 had intact cognition. R1 was responsible for R1's healthcare decisions. Surveyor reviewed R1's average volume-assured pressure support (AVAP) orders and noted the following: ~ Clean AVAP mask daily, one time a day (start date 12/14/23) On 3/24/26 at 10:03 AM, Surveyor interviewed R1 who indicated lack of AVAP mask cleaning started the irritation on R1's face along along with staff popping a pimple. R1 was diagnosed with cellulitis of the face on 12/15/25. Surveyor reviewed R1's December 2025 Treatment Administration Record (TAR) which did not contain an order to clean the AVAP mask on 12/4/25. (See interview under example 3.) 2. On 3/24/26, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] and had diagnoses including obesity and obstructive sleep apnea. R2's MDS assessment, dated 3/2/26, had a BIMS score of 15 out of 15 which indicated R2 had intact cognition. R2 was responsible for R2's healthcare decisions. Surveyor reviewed R2's CPAP orders and noted the following: ~ Clean CPAP mask, headgear, and tubing with mild soap and warm water. Rinse tubing thoroughly and hang to air dry. Do not use alcohol or bleach products on machines or mask each morning every Friday for sleep apnea care (start date 12/14/24) On 3/24/26 at 11:00 AM, Surveyor interviewed R2 who indicated R2's CPAP mask was washed once since admission. Surveyor reviewed R2's March 2026 TAR and noted CPAP cleaning was documented with a 4 on 3/6/26 and 3/16/26 which indicated a nursing progress note indicated why the treatment was not completed. R2's medical record did not contain nursing progress notes regarding CPAP cleaning. On 3/24/26 at 11:40 AM, Surveyor interviewed Director of Nursing (DON)-B who verified R2's medical record did not contain progress notes for 3/6/26 and 3/16/26 to indicate why R2's CPAP was not cleaned. 3. On 3/24/26, Surveyor reviewed R3's medical record. R3 was admitted to the facility on [DATE] and had diagnoses including acute and chronic respiratory failure with hypoxia. R3's MDS assessment, dated 3/2/26, had a BIMS score of 14 out of 15 which indicated R3 had intact cognition. R3 had an activated Power of Attorney for Healthcare (POAHC). Surveyor reviewed R3's BiPAP orders and noted the following: ~ Clean BiPAP mask one time a day (start date 2/14/26) On 3/24/26 at 11:20 AM, Surveyor interviewed R3 who was unsure if staff cleaned R3's BiPAP mask daily. Surveyor reviewed R3's March 2026 TAR and noted BiPAP cleaning was not documented on 3/4/26. On 3/24/26 at 11:15 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-E who indicated nurses are responsible for cleaning CPAP/BiPAP/AVAP masks and document the cleaning in the resident's TAR. On 3/24/26 at 2:47 PM, Surveyor interviewed DON-B who indicated CPAP/BIPAP/AVAP masks should be cleaned once daily with soap and water and the tubing should be cleaned once weekly. DON-B indicated staff are expected to document completion in the resident's TAR. DON-B verified the missing dates of completion for R1, R2, and R3.

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 03/25/2026
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)
F 0760 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff and resident interview and record review, the facility did not ensure 1 resident (R) (R1) of 1 sampled resident was free of a significant medication error. R1 was prescribed clindamycin (an antibiotic) for facial cellulitis following a hospital visit on 12/15/25. R1 missed five doses of the antibiotic when it was not available from the pharmacy. The facility did not update the physician about the missed doses. R1's wound worsened and R1 requested to be transferred to the hospital again on 12/17/25. R1's wound was irrigated, debrided, and packed. R1 received intravenous (IV) antibiotics and was discharged with wound care orders and oral antibiotics. Findings include: The facility's Medication Administration policy, revised November 2024, 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 in a manner to prevent contamination or infection. On 3/24/26, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including cellulitis of the left cheek. R1's Minimum Data Set (MDS) assessment, dated 1/2/26, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R1 had intact cognition. R1 was responsible for R1's healthcare decisions. A progress note, dated 12/15/25 at 7:58 PM, indicated R1 had a swollen area that was approximately 4 to 5 centimeters (cm) in diameter on the left upper cheek that was hard, red, warm to the touch, and painful. R1 stated R1 had the area for at least 3 days and it kept getting bigger, warmer, and more painful. The note indicated the writer worked on another wing the day before (12/14/25) but saw the area and noted it was more noticeable, larger in size, and appeared worse on 12/15/25. The area contained a 0.25 cm area in the center that appeared open but was not draining. R1 tried warm compresses and salve on 12/14/25 but they did not help. R1 stated R1 could not sleep last night because R1's continuous positive airway pressure (CPAP) mask sits on top of the sore and it hurts to wear the mask. R1 was concerned the area was infected and contemplated going to the emergency room (ER) for evaluation. The writer checked the facility's medical record system and did not see any requests to the physician for advisement. R1 stated R1 would let the writer know if the area became more painful to determine if the writer should notify the on-call physician. A progress note, dated 12/15/25 at 9:15 PM, indicated R1 requested to be sent to the ER for treatment. The writer contacted Emergency Medical Services (EMS) for transport. A progress note, dated 12/15/25 at 10:50 PM, indicated R1 returned from the hospital. R1 was treated with clindamycin for facial cellulitis and had the following order: Clindamycin HCL oral capsule 300 milligrams (mg) give 1 capsule by mouth three times daily for facility cellulitis related to cutaneous abscess of face (start date 12/16/25). R1's Medication Administration Record (MAR) indicated due to medication unavailability, three doses of clindamycin were not administered ton 12/16/25 and two doses were not administered on 12/17/25. The PM dose was administered on 12/17/25. R1's medical record indicated the cellulitis became more painful and R1 requested to be transported to the hospital on [DATE] at 11:33 PM. A hospital Discharge summary, dated [DATE] to 12/18/25, indicated R1 had a possible abscess within the soft tissues of the left cheek that measured 1.5 cm x 1.7 cm. The area did not appear amenable to drainage in the ER. Imaging was consistent with preseptal cellulitis (a common infection of the eyelid skin and soft tissues anterior to the orbital septum), not orbital cellulitis (a serious sight- and life-threatening infection of the soft tissues behind the eye socket). R1 was administered clindamycin and instructed to follow-up with R1's physician in 1 to 7 days. R1's medical record indicated the cellulitis became more painful on 12/20/25 and R1 requested to go to the hospital again. A hospital Discharge summary, dated [DATE] to 12/26/25, indicated R1 was admitted to the hospital with a 1 cm x 1.4 cm methicillin-resistant Staphylococcus (MRSA) left cheek abscess with preseptal cellulitis. Irrigation and debridement were completed on 12/20/25. R1 was admitted to the hospital and treated with IV vancomycin through 12/23/25. On 12/24/25, the wound was irrigated (continued on next page)

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	03/25/2026

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 0760 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	with 10 milliliters (ml) of saline, debrided, and packed with non-iodinated ribbon gauze. The wound was covered with a 2 x 2 gauze and secured with paper tape. R1 was discharged on 12/26/25 with an order to continue cleansing and packing the wound twice daily until healed. R1 also had an order for TMP/Sulfa Double Strength (DS) (an antibiotic) twice daily for 7 to 14 days until healed. On 3/24/26 at 2:47 PM, Surveyor interviewed Director of Nursing (DON)-B who stated the facility did not have clindamycin in contingency and the pharmacy was unable to deliver it timely. DON-B called the pharmacy numerous times to expedite the delivery; however, clindamycin was not delivered until the 12/17/25 PM shift. DON-B indicated the facility added clindamycin to their contingency stock to prevent it from happening in the future. DON-B verified R1 missed a total of five doses of clindamycin from 12/16/25 to 12/17/25.