STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525678	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careview Health and Rehab of Minocqua	9969 Old Hwy 70 Rd Minocqua, WI 54548

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 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. (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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility did not consult with a physician when unable to obtain a wound VAC (vacuum assisted closure) and vancomycin solution, as ordered per hospital discharge instructions, for 1 of 3 residents reviewed (R1). R1 was admitted to the facility on [DATE] at approximately 2:30 PM, after a hospitalization for sepsis related to necrotizing fasciitis and Fournier's gangrene (gangrene affecting the external genitalia or perineum), of the right groin. R1 scored 12/15 during Brief Interview for Mental Status (BIMS), indicating moderately impaired cognition.R1 was hospitalized from [DATE]-[DATE]. R1 suffered a stroke during her hospitalization, was intubated, and required mechanical ventilation, R1 was successfully extubated prior to her discharge from the hospital. During R1's hospitalization, she required multiple debridements of right groin wound, and extensive antibiotic therapy. A Foley catheter was placed to keep the area clean. Last noted wound measurements were on 10/31/25, 20 x 11 x 2 cm. Upon R1's hospital discharge, she was discharged from infectious disease (ID) with recommendations for initiation of a wound VAC.On 11/03/25, R1's hospital discharge summary included the following as it relates to her wound:-Augmentin for six more days on discharge, no need to follow with ID.- She is supposed to get a wound Vac today in SNF.-Vancomycin 1% irrigation, apply twice daily to affected area.-Instructions: BID (twice daily) vancomycin to wound kerlex until wound vac on. R1's facility physician orders included:-11/03/25, Augmentin 500-125 mg two time a day for skin and soft tissue infection.-Acetaminophen, 500 mg. Give two tablets, three times per day. On 11/04/25, Nurse Practitioner (NP) completed a face-to-face visit with R1 in the facility. NP note included, Continue wound VAC when available. On 11/05/25, R1's progress notes read, Wound change due. Resident required moist gauze dressing change. Due to vancomycin solution not delivered by pharmacy yet, so per NP ok to do a wet to dry dressing change. Resident tolerated procedure well. R1's November treatment administration record (TAR) included:-11/05/25, Location of wound: right groin, wound treatment: Wet to dry dressing and cover with bordered gauze until the vancomycin solution comes in. Start Date 11/05/2025.(Note, this is the only order entered in TAR related to R1's wound care. Documentation shows treatment was completed on 11/05/25 in the AM only. Pain level was 0). On 11/06/25, a progress note written by Doctor of Medicine (MD) C, present in the facility, read in part, Attention is brought to the patient pain, also supposedly to get the wound VAC on initial admission on [DATE], but that has not materialized. Also, the right groin wound is contaminated with significant stool. The initial plan was to get a wound VAC at the skilled nursing facility where she was at on the day of discharge the wound VAC was supposed to arrive on the same day unfortunately that has never materialized. The goal of the wound VAC was to at least keep it free from contamination with feces and thereby exposing further the wound to infection. When I arrive it is brought to my attention that the patient is in significant pain of the right groin. Patient is also followed feces and stool where the whole right groin area including muscle exposure very deep wound are all covered with stool.At this point decision has been made to send the patient back to a local emergency room for application of wound VAC.Plan: patient will be sent to local emergency room once again the patient will need a wound VAC application after wound is cleaned and free from feces. The patient would really need wound VAC should be applied prior to discharge to skilled nursing facility and if there is a need to switch the wound VAC the nursing facility could switch it and ensure there is no contamination of stool to the right wound because that is the primary goal. Also it would allow healing and that the patient could have grafting skin graft down the road. On 11/24/25 at 12:04 PM, Surveyor interviewed Registered Nurse (RN) F. RN F reported she was present when R1 admitted but was not R1's admitting nurse. The admitting nurse was from an agency. RN F stated R1's admitting orders included wound care orders, but again was not sure of the orders as she did not admit R1. RN F stated, We didn't know she (R1) was supposed to have vancomycin solution. RN F reported on 11/05/25, she worked on the hall R1 resided on and noted R1 had a wound without wound care orders. RN F stated she called NP D for an order to complete a wet-to-dry dressing change. RN F reported no concerns related to R1 having pain. On 11/24/25 at 12:15 PM, Surveyor interviewed MD C. MD C was able to recall the situation with R1, stating R1's wound appeared as if it had been packed with stool. Surveyor asked MD C about R1's orders for vancomycin solution twice daily and a wound VAC. MD C stated, I don't really know what to say. Whatever is not written was not done. MD C confirmed the wound VAC would help keep the wound from being contaminated with stool as. The wound was in a bad area. MD C was not sure why wound VAC was not delivered to the facility

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure a baseline care plan was developed and implemented for each resident (R) within 48 hours of admission for 1 of 3 residents reviewed (R1).R1 was admitted with a non-pressure related wound and wound care orders; a baseline care plan for wound care was not developed. R1 was admitted to the facility on [DATE] at approximately 2:30 PM, after a hospitalization for sepsis related to necrotizing fasciitis and Fournier's gangrene (gangrene affecting the external genitalia or perineum), of the right groin. R1 scored 12/15 during Brief Interview for Mental Status (BIMS), indicating moderately impaired cognition.R1 was hospitalized from [DATE]-[DATE]. R1 suffered a stroke during her hospitalization, was intubated, and required mechanical ventilation, R1 was successfully extubated prior to her discharge from the hospital. During R1's hospitalization, she required multiple debridements of right groin wound, and extensive antibiotic therapy. A Foley catheter was placed to keep the area clean. Last noted wound measurements were on 10/31/25, 20 x 11 x 2 cm. Upon R1's hospital discharge, she was discharged from infectious disease (ID) with recommendations for initiation of a wound VAC.On 11/03/25, R1's hospital discharge summary included the following as it relates to her wound:-Augmentin for six more days on discharge, no need to follow with ID.- She is supposed to get a wound Vac today in SNF.-Vancomycin 1% irrigation, apply twice daily to affected area.-Instructions: BID (twice daily) vancomycin to wound kerlex until wound vac on. R1's facility physician orders included:-11/03/25, Augmentin 500-125 mg two time a day for skin and soft tissue infection.-Acetaminophen, 500 mg. Give two tablets, three times per day. R1's care plan included:-11/04/25, Foley catheter-11/05/25, Advanced Directives(Note, R1's care plan did not include wound care). On 11/24/25 at 3:20 PM, Surveyor interviewed Licensed Practical Nurse (LPN) B. LPN B confirmed a baseline care plan for wound care was not developed for R1.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure residents received care and treatment in accordance with professional standards of practice and the comprehensive person-centered care plan for 1 of 3 residents (R) reviewed for quality of care (R1).-R1 did not receive wound care as ordered.-The facility did not order R1's wound VAC (vacuum assisted closure), as ordered.-The facility did not implement a baseline care plan related to R1's wounds.R1 was admitted to the facility on [DATE] at approximately 2:30 PM, after a hospitalization for sepsis related to soft tissue injury of necrotizing fasciitis and Fournier's gangrene (gangrene affecting the external genitalia or perineum), of the right groin. R1 scored 12/15 during Brief Interview for Mental Status (BIMS), indicating moderately impaired cognition.R1 was hospitalized from [DATE]-[DATE]. R1 suffered a stroke during her hospitalization and was intubated. During R1's hospitalization, she required multiple debridements of right groin wound, and extensive antibiotic therapy. A Foley catheter was placed to keep the area clean. Last noted wound measurements were on 10/31/25, 20 x 11 x 2 cm. Upon R1's hospital discharge, she was discharged from infectious disease (ID) with recommendations for initiation of a wound VAC.On 11/03/25, R1's hospital discharge summary included the following as it relates to her wound:-Augmentin for six more days on discharge, no need to follow with (Infectious Disease (ID).- She is supposed to get a wound Vac today in SNF.-Vancomycin 1% irrigation, apply twice daily to affected area.-Instructions: BID (twice daily) vancomycin to wound kerlix until wound vac on.R1's facility physician orders included:-11/03/25, Augmentin 500-125 mg two time a day for skin and soft tissue infection.-Acetaminophen, 500 mg. Give two tablets, three times per day. R1's care plan included:-11/04/25, Foley catheter-11/05/25, Advanced Directives(Note, R1's care plan did not include wound care).On 11/04/25, Nurse Practitioner (NP) completed a face-to-face visit with R1 in the facility. NP note included, Continue wound VAC when available.On 11/05/25, R1's progress notes read, Wound change due. Resident required moist gauze dressing change. Due to vancomycin solution not delivered by pharmacy yet, so per NP ok to do a wet to dry dressing change. Resident tolerated procedure well.R1's November treatment administration record (TAR) included:-11/05/25, Location of wound: right groin, wound treatment: Wet to dry dressing and cover with bordered gauze until the vancomycin solution comes in. Start Date 11/05/2025.(Note, this is the only order entered in TAR related to R1's wound care. Documentation shows treatment was completed on 11/05/25 in the AM only. Pain level was 0).The only dressing change completed for R1's wound was on 11/05/25 in the AM. No dressing changes noted on 11/03/25 or 11/05/25.On 11/06/25, a weekly skin evaluation was completed for R1, documentation included:-Wound type: pressure ulcer-Location: groin-Stage: unstageable-Undermining: yes-Tunneling: yes-Tissue type: slough-Exudate: minimal, purulent, yellow-Odor: no-Wound bed appearance: Red, yellow, pink-Surrounding skin: pink-Wound margins: clean and intact-Has the wound shown improvement? - Not applicable-newThe facility skin assessment of the tissue injury is not accurate. The wound is not a pressure injury. It is a soft tissue injury of necrotizing fasciitis and Fournier's gangrene (gangrene affecting the external genitalia or perineum), of the right groin.The last known measurement of this soft tissue injury was on 10/31/25 while R1 was in the hospital. The facility did not measure this on admission on [DATE].The facility did not ensure a wound vac was provided for R1 upon admission. R1 did not have a wound vac from admission date of 11/03/25 through 11/06/25, when R1 was sent to the hospital for care and treatment of the soft tissue injury being impacted with stool. Wound vac did not arrive to the facility until 11/06/25 at 9:30 AM, prior to R1 being sent out to hospital. The right groin area wound included muscle exposure; last known measurement from 10/31/25 was 20 x 11 x 2 cm. This wound was very deep and was all covered with stool.On 11/06/25, a progress note written by Physician Assistant-Certified (PA-C) E, present in the facility, read in part, Provider was summoned to aid with a shower as patient had soiled her bedding due to diarrhea. Unfortunately, wound VAC was not in place. Therefore, the wound of the groin was soiled with BM. Patient had significant pain when leaning to right side on right buttock in shower chair. Discussed with primary care secondary to unclean wound without wound VAC in place and significant pain.On 11/06/25, a progress note written by Doctor of Medicine (MD) C, present in the facility, read in part, Attention is brought to the patient pain, also supposedly to get the wound VAC on initial admission on [DATE], but that has not materialized. Also, the right groin wound is contaminated with significant stool. The initial plan was to get a wound VAC at the skilled nursing facility where she was at on the day of discharge the wound VAC was supposed to arrive on the