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	01/27/2026

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. Based on interview and record review, the facility did not ensure residents were free from misappropriation for 1 of 1 resident (R29).-On 01/07/26, the facility was made aware R29 was missing personal property, including $80.00.-The facility did not protect R29 from misappropriation.-The facility did not report this to the State Agency (SA).-The facility did not begin an investigation until 01/09/26.-The facility did not conduct a thorough investigation of R29's missing property.-The facility was unable to locate R29's missing property.The facility policy titled, Abuse prevention, read in part, Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation.3. Develop and implement policies and procedures to aid our facility in preventing abuse, neglect, or mistreatment of our residents.4. Require staff training/orientation programs that include such topics as abuse prevention, identification and reporting of abuse, stress management, and handling verbally or physically aggressive resident behavior. 6. Identify and assess all possible incidents of abuse. 7. Investigate and report any allegations of abuse within timeframes as required by federal requirements. 8. Protect residents during abuse investigations.The facility's policy titled, Abuse Investigation and Reporting, read in part, All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported.C. Interview the person reporting the incident. D. Interview any witnesses to the incident. E. Interview the resident (as medically appropriate). G. Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident.On 01/11/26, Surveyor reviewed a complaint submitted to the SA On 01/08/26, by Family Member (FM) N. The complaint included R29 was noted to have several missing items including a cell phone, cell phone charger, wallet with $80.00 in it, tennis shoes, two grabbers, and wicker box including household items such as keys.On 01/11/26, Surveyor requested the facility's investigation. Social Worker (SW) F told Surveyor the facility had not completed R29's investigation yet. Surveyor asked SW F for documentation of what the facility had completed, and SW F stated, Ok. Surveyor did not receive the requested documentation on 01/11/26.On 01/11/26 at 1:44 PM, Surveyor called FM N. FM N stated she had filed two grievances related to missing items; the most recent grievance was filed approximately 01/07/26. FM N verified the missing items listed in the complaint were accurate. FM N reported the facility stated they were completing their own internal investigation. FM N also reported the incident to law enforcement. FM N has not received additional information related to the missing items.On 01/11/26, Surveyor reviewed the facility's grievance log for the previous three months. Surveyor noted a grievance filed on 10/06/25, related to communication and lack of cares. There were no other grievances for R29. Surveyor requested the facility's grievance policy but was not provided with this.On 01/12/26, Surveyor requested the facility's internal investigation related to R29's missing property. Surveyor did not receive (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

Printed: 04/02/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525678	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/27/2026
NAME OF PROVIDER OR SUPPLIER Careview Health and Rehab of Minocqua		STREET ADDRESS, CITY, STATE, ZIP CODE 9969 Old Hwy 70 Rd Minocqua, WI 54548	

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	this.On 01/13/26, Surveyor requested the facility's internal investigation related to R29's missing property. Director of Nursing (DON) J stated the facility was unable to locate R29's missing items and would be calling FM N to provide an update. Surveyor requested to review the facility's investigation.DON J provided Surveyor with a single page titled, Grievance/Complaint form, dated 01/07/26. Complainant was FM N and reported to Nursing Home Administrator (NHA) A. Items missing were listed as 1. Men's watch (brown band), 2. Burgundy/Red cell phone and charger, 3. Two grabbers, 4. One pair of black/white tennis shoes, 5. Octagon wood box (had keys in it), 6. Wallet ($80 cash).The grievance was assigned to Assistant Nursing Home Administrator (NHA) B, on 01/09/26, with a resolution date of 01/14/26. Actions were staff searched R29's room and laundry for missing items. Let laundry go a couple of days and then checked again sill not able to locate items. Called daughter to discuss replacing items. She said she would call us back. Resolution was, Waiting on daughter to call back so we can make a plan to replace items.The facility did not provide any additional information related to the investigation of R29's missing property.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview and record review the facility did not ensure a thorough investigation of an allegation of abuse for 2 of 2 residents (R8 and R29).-On 01/07/26, the facility was made aware R29 was missing personal property, including $80.00. -The facility did not begin an investigation until 01/09/26.-The facility did not conduct a thorough investigation of R29's missing property, by conducting staff or resident interviews.-The facility was unable to locate R29's missing property.-R8 was found to have a pelvic fracture and no root cause.-The facility did not investigate the cause by conducting further staff interviews and interviewing R8 or representative.-The facility did not complete education to all staff per intervention related to incident.The facility policy titled, Abuse prevention, read in part, Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation.3. Develop and implement policies and procedures to aid our facility in preventing abuse, neglect, or mistreatment of our residents.4. Require staff training/orientation programs that include such topics as abuse prevention, identification and reporting of abuse, stress management, and handling verbally or physically aggressive resident behavior. 6. Identify and assess all possible incidents of abuse. 7. Investigate and report any allegations of abuse within timeframes as required by federal requirements. 8. Protect residents during abuse investigations. The facility's policy titled, Abuse Investigation and Reporting, read in part, All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported.C. Interview the person reporting the incident. D. Interview any witnesses to the incident. E. Interview the resident (as medically appropriate). G. Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident. Example 1 On 01/11/26, Surveyor requested the facility's investigation. Social Worker (SW) F told Surveyor the facility had not completed R29's investigation yet. Surveyor asked SW F for documentation of what the facility had completed, and SW F stated, Ok. Surveyor did not receive the requested documentation on 01/11/26. On 01/11/26 at 1:44 PM, Surveyor called FM N. FM N stated she had filed two grievances related to missing items; the most recent grievance was filed approximately 01/07/26. FM N verified the missing items listed in the complaint were accurate. FM N reported the facility stated they were completing their own internal investigation. FM N also reported the incident to law enforcement. FM N has not received additional information related to the missing items. On 01/11/26, Surveyor reviewed the facility's grievance log for the previous three months. Surveyor noted a grievance filed on 10/06/25, related to communication and lack of cares. There were no other grievances for R29. Surveyor requested the facility's grievance policy but was not provided with this. On 01/12/26, Surveyor requested the facility's internal investigation related to R29's missing property. Surveyor did not receive this. On 01/13/26, Surveyor requested the facility's internal investigation related to R29's missing (continued on next page)

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

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	property. Director of Nursing (DON) J stated the facility was unable to locate R29's missing items and would be calling FM N to provide an update. Surveyor requested to review the facility's investigation. DON J provided Surveyor with a single page titled, Grievance/Complaint form, dated 01/07/26. Complainant was FM N reported to Nursing Home Administrator (NHA) A. Items missing were listed as 1. Men's watch (brown band), 2. Burgundy/Red cell phone and charger, 3. Two grabbers, 4. One pair of black/white tennis shoes, 5. Octagon wood box (had keys in it), 6. Wallet ($80 cash). The grievance was assigned to Assistant Nursing Home Administrator (NHA) B, on 01/09/26, with a resolution date of 01/14/26. Actions were staff searched R29's room and laundry for missing items. Let laundry go a couple of days and then checked again sill not able to locate items. Called daughter to discuss replacing items. She said she would call us back. Resolution was, Waiting on daughter to call back so we can make a plan to replace items. The facility did not provide any additional information related to the investigation of R29's missing property. Example 2 R8 was most recently admitted to facility from a hospitalization on 12/30/25 but has resided at facility since 08/2024. On 01/05/26, R8 had a Brief Interview for Mentals Status (BIMS) score of 9/15 which indicates moderate cognitive impairment. R8's care plan includes a focus of R8 is at risk for falls related to diabetic neuropathy, Parkinson's, and history of stroke. R8 has a history of falls in the facility including witnessed falls on 09/14/25, 09/19/25, and 10/20/25, and unwitnessed falls on 10/12/25, 10/15/25,10/20/25, and 10/27/25. Care plan includes goal of R8 will not sustain serious injury by review date last revised on 09/30/25 with a target date of 02/19/26. Interventions include in part: anti-roll back brakes on wheelchair (01/21/25), Dycem to wheelchair and recliner (10/15/25), Scoop mattress (10/20/25), R8 to be assisted to bathroom after meals (10/28/25), low bed and fall mat (02/16/25), new flat fall mat so wheelchair can be locked next to bed (04/02/25), empty foley catheter approximately every 4 hours throughout shift (09/10/24), anticipate and meet R8's needs (11/07/24), and follow facility fall protocol (09/14/25). On 01/06/26 in the morning, R8 displayed onset of pain and initially denied falling. The provider notified staff to assess resident and ordered x-rays. Staff continued to monitor R8 throughout the shift. R8 was offered pain medication. Due to mobile x-ray not able to make it timely, R8 was sent to the emergency room (ER) for evaluation. Upon evaluation, it was determined R8 had a pelvic fracture. Interventions included education with staff on reporting all changes of condition to provider and family. This information was submitted to the State on 01/07/26. On 01/13/26, Surveyor requested complete investigation and final report. Surveyor reviewed Investigation Worksheet. Worksheet indicated the involved parties were Licensed Practical Nurse (LPN) EE and Certified Nursing Assistant (CNA) P and LPN EE was a potential witness to the event. Worksheet indicated hospital staff interviewed R8 and that no interview was conducted (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	by facility staff with R8. Statement from LPN EE states LPN EE worked on 01/06/26 around 5:00 PM. LPN EE observed R8 sitting on the edge of the bed, half on/half off. LPN EE stated LPN EE assisted R8 back to bed and there were no signs/symptoms of pain. LPN EE stated LPN EE visited R8 multiple times throughout the night with no signs or symptoms of pain or fall. Included in the investigation paperwork provided to the Surveyor was a progress note with no date, time, or author that stated R8 had complaints of pain to left hip around 7:30 AM. R8 denied any falls throughout the night. R8 was given Acetaminophen at 7:45 AM. Provider notified and ordered x-ray to left hip area. A skin assessment was completed by Director of Nursing in training C. Bruising was noted from intravenous sites on arms and from recent falls but no other signs or symptoms. Mobile x-ray company called facility around 3:00 PM to state they would not be able to come that day due to weather. Provider was notified and gave orders to send R8 to the ER for imaging and assessment. R8's spouse was notified and agreeable to plan. Statement from CNA P states CNA P went to R8's room at 2:00 AM on 01/06/26, due to R8 calling out for help. CNA P stated R8 stated R8 did not need anything. CNA P stated a few hours later R8 called out but did not have any concerns or complaints. CNA P stated R8 appeared restless. CNA P stated CNA P then emptied R8's Foley catheter bag at around 5:45 AM and R8 was asleep at this time. CNA P stated this was CNA P's last interaction with R8. Investigation Worksheet indicated a complete physical and emotional assessment of R8 identifying any areas of injury was not completed. R8's environment was observed to have no abnormalities. No new interventions noted. Investigation Worksheet indicated facility should interview any potential witnesses 48-72 hours prior to incident. 2 staff interviews completed (LPN EE and CNA P). 5 Safe Surveys were completed. Safe Surveys ask other residents if staff assists them, answer call lights timely, makes them feel safe, and if anyone is rough, if they have concerns, and if they are satisfied with their care. No concerns noted with these surveys. Investigation Worksheet included the following: Information gathered to conclude how incident occurred, establish reasonable cause, establish need for further investigation with a response of more frequent rounding. Conclude why the incident occurred- with no response. Were identified re-evaluation, care plan revisions, staff training, equipment modification, or other corrective actions completed- with no response. Was documentation in resident record completed- with a response of no documentation complete. On 01/13/26, Surveyor interviewed Nursing Home Administrator (NHA) A and Assistant NHA B. NHA A stated the paperwork sent into the state was the completed 5-day investigation. Assistant NHA B stated Assistant NHA B was working on obtaining hospital documentation and would provide copies to Surveyor. NHA A stated there was no other investigation done outside of what was provided to Surveyor and the State. Surveyor reviewed R8's hospital x-ray report of the left hip. Findings: Markedly comminuted fracture of the anterior, posterior, and superior left acetabular walls are visualized.Nondisplaced fracture of the left inferior pubic ramus is visualized.trace hemorrhage in the left hemipelvis and peri vesical space. There is likely small volume hemorrhage in the left iliopsoas muscle. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed staff education provided after incident. Power of Attorney notification and change of condition, and Falls education provided to 3 staff only. (LPN S, LPN K, and LPN FF) Surveyor determined the facility did not complete a thorough investigation related to finding a root cause, providing all-staff education, conducting further interviews, and ruling out abuse.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility did not ensure residents/representatives received notice of bed-hold policy indicating reserve payment and did not receive notice before indicating specific reason for the transfer/discharge for 5 of 5 residents (R2, R7, R8, R14, and R43).Example 1 R43 was admitted to the facility on [DATE]. On 10/10/25, R43 scored 15/15 during Brief Interview for Mental Status (BIMS), indicating intact cognition. R43 was transferred to the hospital on 1/5/26. Surveyor noted a summary that was sent with R43 upon transfer. On 1/12/25 at 12:11 PM, Social Worker F reported she does not have bed-hold notice for R43's hospital transfer. Example 2 R8 was admitted to the facility on [DATE]. On 01/05/26, Brief Interview for Mental status score was 9/15, indicating moderate cognitive impairment. On 01/07/26, R8 was admitted to the hospital for hip pain in relation to injury of unknown origin. There was no bed hold notice provided to R8 or representative related to transfer to hospital on [DATE]. Example 3 R7 was transferred to hospital for change in condition on 11/23/2025 and 01/10/2026 and was not provided a notice of bed hold indicating reserve paymentand did not receive notice before transfer/discharge indicating specific reason for the transfer/discharge. Surveyor attempted to interview Social Worker F regarding resident transfer/discharge process who was out ill last part of survey. Assistant Nursing Home Administrator (ANHA) B was not aware of process and would have to ask Nursing Home Administrator (NHA) A. At time of survey exit, there was no follow up from ANHA B or NHA A. Example 4 R2 was admitted to the facility on [DATE]. On 12/11/25, R2 scored 15/15 during Brief Interview for Mental Status (BIMS), indicating intact cognition. R2 was transferred to the hospital on [DATE]. R2's bed-hold notice was signed on 11/13/25 noting, I wish to reserve my room. R2's bed-hold notice was signed by a care manager from a Managed Care Organization (MCO). (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R2's bed-hold notice did not include the daily rate for reservation. Example 5 R14 was admitted to the facility on [DATE]. On 12/17/25, R14 scored 15/15 during BIMS assessment indicating intact cognition. R14 was transferred to the hospital on [DATE]. R14's bed-hold notice was signed on 12/30/25 noting, I wish to reserve my room. R14's bed-hold notice was signed by a care manager from a MCO. R14 was transferred to the hospital on [DATE]. There was no bed-hold notice provided to R14 for this transfer.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not provide care and treatment by professional standards of practice to maintain a resident's highest practicable level of physical well-being for 2 of 15 residents (R29 and R62).-The facility did not follow physician orders to monitor R29's blood pressure.-The facility did not follow orders to assess and provide dressing changes to R62's lower extremities. R62 was admitted to the facility on [DATE] with pertinent diagnosis including chronic osteomyelitis, right ankle and foot, type 2 diabetes mellitus with foot ulcerations, sepsis, non-pressure chronic ulcer of other part of right foot with necrosis of bone, and non-pressure chronic ulcer of other part of left foot with necrosis of bone. On 1/9/26, a Minimum Data Set (MDS) assessment indicated R62 did not have a Brief Interview for Mental Status (BIMS) completed. Surveyor requested physician's orders. Documentation the facility provided in R62's order summary report did not include wound care treatment. R62's Treatment Administration Record (TAR) indicated: Active on 1/5/26, bilateral lower extremities - 3rd toe amputation site. apply non adherent dressing and secure with gauze wrap every night shift and as needed. Monitor for signs/symptoms of infection. Document drainage. Document Pain Score. R62's initial care plan initiated on 1/11/26 did not address R62's wounds or have interventions pertaining to wound care. On 1/11/2026 at 1:25 PM, Surveyor observed loose gauze wraps on R62's feet. Surveyor interviewed R62, who reported wounds on both feet, amputations of his toes. R63 reported he does not think dressing changes have been done to his lower extremities since his admission. On 1/12/2026 at 9:00 AM, Surveyor interviewed Licensed Practical Nurse (LPN) V. Surveyor requested to observe R62's dressing change. LPN V reported R62's dressing changes to his feet are as needed. Surveyor asked where LPN V would document wound assessments and dressing changes. LPN V reported in the TAR. Surveyor noted there was no documentation in the TAR of daily assessments or dressing changes done to R62's lower extremities from 1/5/26 to 1/10/26. On 1/13/2026 at 10:30 AM, Surveyor interviewed Director of Nursing (DON) J requesting documentation of daily dressing changes to R62' s feet. DON J agreed the orders in the TAR are to provide daily dressing change to R62's lower extremities and there is only documentation of the dressing change being done on 1/11 and 1/12/26. Surveyor asked if R62's dressings were then not changed on 1/5 through 1/10/26. DON J stated that is what the documentation is indicating. Example 2 R29 was admitted to the facility on [DATE] with diagnoses including hypertension, chronic kidney disease, and cognitive decline. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/17/25, a Minimum Data Set (MDS) assessment indicated R29 scored 11/15 during Brief Interview for Mental Status (BIMS) indicating moderately impaired cognition. R29's physician orders included: -Carvedilol, twice daily for hypertension. -Entresto, once daily for hypertension. -Torsemide, once daily for heart disease. Note, torsemide is a diuretic used to manage hypertension. On 12/21/25, R29's progress notes read, Nurse was notified by staff that resident was on the floor at 0900am this morning. Nurse saw resident sitting in front of recliner with the chair raised all the way up. Resident was sitting straight up with back against the recliner and feet and legs in front of him straight out touching his dresser. Resident was incontinent, and able to speak clearly to the nurse. Resident is A&O x3, VS stable aside from BP running a little low. Resident has no injuries present and no complaints of pain present. Resident told nurse that they slid out of their chair due to the floors being slippery. Nurse did notice resident was wearing grippy socks when they were found on the floor. Resident said they were trying to get to the bathroom. Nurse notified NP, DON, and POA. POA did not answer so nurse left voicemail. Nurse assessed VS, Skin, Pain levels, pushed fluids, got resident off the floor and assessed BS again. Nurse was instructed by NP to push fluids and assess BP every hour to determine if they needed to be sent in. Nurse was able to get BP up to an acceptable level according to the NP. Nurse was then told to hold all BP medications until BP reached proper levels. Surveyor reviewed R29's Medication Administration Record (MAR). Surveyor noted anti-hypertensive medications were held on 12/21/25. All medications were given as ordered on 12/22/25 and the morning of 12/23/25. Surveyor was unable to find documentation of blood pressure readings after the initial incident on 12/21/25. On 12/23/25, R29 was seen by primary provider at the facility. Primary provider ordered labs to be completed. Prior to labs being completed, family requested R29 be sent to the emergency room, related to the family's concerns of R29 complaining of pain and slumped over in his wheelchair. R29 was admitted to the hospital with diagnoses of acute kidney failure, urinary tract infection, and cellulitis. On 01/14/26 at 11:58 AM, Surveyor interviewed DON J. DON J stated she was unable to find documentation nursing staff had followed orders to monitor blood pressure until blood pressure reached acceptable levels. DON J was unable to find documentation medications were held as ordered.

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure 1 of 5 residents (R43) received care, consistent with professional standards of practice, to prevent pressure injuries and received necessary treatment and services to promote healing, prevent infection and prevent new pressure injuries (PI) from developing.R43 was at risk for pressure injury development. The facility failed to implement aggressive interventions to prevent PI development, ensure treatment orders were completed as ordered, and failed to complete a comprehensive assessment upon discovery of a new PI on R43's left heel. R43 developed an avoidable pressure injury (PI) that deteriorated to stage IV with osteomyelitis requiring hospitalization and intravenous antibiotic therapy. This created a finding of immediate jeopardy that began on [DATE]. Surveyor notified Nursing Home Administrator (NHA) A of the immediate jeopardy on [DATE] at 2:10 PM. The immediate jeopardy was removed on [DATE]. The deficient practice continues at a scope and severity of E (potential for more than minimal harm that is not immediate jeopardy/pattern) as the facility continues to implement its action plan.This is evidenced by:The facility's policy titled, Pressure Ulcer/Skin Breakdown- Clinical Protocol, revised [DATE], states in part, Assessment and Recognition . 3. The physician and staff will examine the skin of new admission for ulcerations or indications of Stage 1 pressure area that has not yet ulcerated at the surface. Treatment and Management . 1. The physician will authorize pertinent orders related to wound treatments . Monitoring . 2. The physician will help staff review and modify the care plan as appropriate, especially when . new wounds develop despite existing interventions.According to the National Pressure Injury Advisory Panel (NPIAP), a stage 3 pressure injury is defined as full-thickness loss of skin in which adipose (fat) is visible in the ulcer, and granulation tissue and rolled wound edges (epibole) are often present. Slough and/or eschar may be visible, but it does not obscure the depth of tissue loss.A stage 4 pressure injury is defined as full-thickness skin and tissue loss with directly palpable or exposed fascia, muscle, tendon, ligament, cartilage, or bone. These deep, often crater-like wounds may include slough, eschar, undermining, and tunneling.<According to https://www.mayoclinic.org/diseases-conditions/osteomyelitis/symptoms-causes/syc-20375913> Osteomyelitis is an infection in a bone. Infections can reach a bone through the bloodstream or from nearby infected tissue. Infections also can begin in the bone if an injury opens the bone to germs. People who smoke and people with chronic health conditions, such as diabetes or kidney failure, are at higher risk of getting osteomyelitis. People who have diabetes with foot ulcers may get osteomyelitis in the bones of their feet. Most people with osteomyelitis need surgery to remove areas of the affected bone. After surgery, most often people need strong antibiotics given through a vein. Risk factors: Healthy bones resist infection. But bones are less able to resist infection as you get older. Besides wounds and surgery, other factors that can increase your risk of osteomyelitis may include Conditions that weaken the immune system. This includes diabetes that isn't well-controlled. Peripheral artery disease. This is a condition in which narrowed arteries cut blood flow to the arms or legs. Pressure injuries. People who can't feel pressure or who stay in one position for too long can get sores on their skin where the pressure is. These sores are called pressure injuries. If a sore is there for a time, the bone under it can become infected. Complications: Osteomyelitis complications may include bone death, also called osteonecrosis. An infection in your bone can block blood flow within the bone, leading to bone death. If you have areas where bone has died, you need surgery to remove the dead tissue for antibiotics to work.R43 was admitted on [DATE] after hospitalization for sepsis with multi-organ failure, type 2 diabetes mellitus without chronic complications, chronic kidney disease stage 3 unspecified, unspecified dementia, type 2 (continued on next page)

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

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	diabetes mellitus with diabetic chronic kidney disease, essential (primary) hypertension, and heart failure unspecified.R43's initial care plan, dated [DATE], contains the goal of having intact skin, free of redness, blisters, or discoloration ongoing and through review date. The care plan identified R43 at increased risk for pressure ulcer development with an intervention of a pressure reducing mattress. Interventions for initial care plan included, administer treatments as ordered, the resident requires pressure reducing mattress to bed, utilize barrier creams with each incontinent episode.A Comprehensive Minimum Data Set (MDS) dated [DATE] indicated no pressure ulcer/injuries and no surgical wounds. The MDS identified R43 was at risk for pressure ulcer development. Of note, the surveyor could not obtain documentation of the tool used to assess this or the score indicating R43's risk for pressure ulcers.The quarterly MDS assessment dated [DATE] indicated R43 had no pressure ulcers/injuries and 1 surgical wound.On [DATE] at 3:30 PM, a wound care progress note written by Medical Doctor (MD) Z stated, R43 had a Stage 3 pressure wound of the right medial buttock, measuring 3.1 cm long x 0.9 cm wide x 0.1 cm deep. This wound on the right medial buttock was resolved on [DATE].On [DATE] at 2:30 PM, R43's medical record had a Situation-Background-Assessment-Recommendation (SBAR) form completed, which indicated resident [R43] has a new wound to the right heel 8cm x 5cm open. Resident [R43] is not voicing any complaints of (c/o) pain at this moment. A bandage is put on wound and wrapped in gauze. Pressure boots were put on the resident while in bed. There was no comprehensive assessment completed which would include characteristics of the wound.Note: documentation of right heel is incorrect. The new wound is on the left heel.On [DATE], R43's TAR indicated, Location of wound left (L) heel. Treatment, at bedtime, cleanse with Normal Saline, pat dry, apply foam dressing, secure in place with Kerlix, change daily. Daily assessment of wound drainage, general appearance, and surrounding skin noted. Surveyor could not find evidence of a comprehensive wound assessment completed on left heel wound until [DATE].On [DATE] at 3:55 PM, wound care progress notes by MD Z, documented R43 had a blister on left heel has ruptured, open wound today. Wound size 4cm long x 6.2 cm wide, depth is not measurable due to presence of nonviable tissue and necrosis. MD Z performed debridement to remove necrotic tissue and establish margins of viable tissue. Post surgical wound of the left heel. MD Z's new wound care treatment plan was to add Betadine to the dressing change and perform dressing change twice a day and as needed: if saturated, soiled or dislodged for 30 days.R43's TAR indicates order was not changed and treatment to R43's left heel remained once a day at bedtime, cleanse with Normal Saline, pat dry, apply foam dressing, secure in place with Kerlix until [DATE]. The new order stating the addition of Betadine to the dressing change and to change the dressing twice daily and as needed; if saturated, soiled or dislodged for 30 days was not transcribed onto TAR nor performed by nursing for R43's wound.On [DATE] at 3:12 PM, a progress note indicates R43 was seen by MD Z. R43's left heel wound measured 3.2 cm long x 2.1 cm wide x 0.1 cm deep. MD Z did debridement of R43's wound. R43's order was changed back to performing wound care once a day. New order written stated, primary dressing, Betadine, apply once daily and as needed: if saturated, soiled, or dislodged for 23 days. Secondary dressing, gauze roll (kerlix) 3.4 apply daily and as needed: if saturated, soiled, or dislodged for 30 days.On [DATE], R43's TAR indicated to start every shift and as needed, left heel, treatment to cleanse with NS, pat dry, paint with betadine, ABD secured and kerlix applied. TAR indicated this was started on [DATE] as ordered and performed until [DATE].R43's care plan was not updated until [DATE] to include R43's actual impairment to skin integrity of the left heel related to surgical wound. An intervention of weekly treatment documentation to include measurement of skin breakdown and to monitor/document location, size, and treatment of skin injury.On [DATE] at 3:14 PM, wound care progress notes by MD Z stated R43's wound measured 3.1 cm long x 5.4 cm wide. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Depth was unmeasurable due to presence of dried fibrinous exudate. MD Z ordered to discontinue betadine and start Hydrofera blue applied once daily and as needed: if saturated, soiled or dislodged for 30 days. And a secondary gauze kerlix for 16 days and gauze island with border applied daily for 30 days.On [DATE] at 12:02 PM, MD Z's progress note stated R43 was hospitalized due to a non-wound matter.On [DATE] at 11: 11 PM, R43's progress note states: R43 arrived to the facility via [transport company name]. Surveyor found no documentation of a comprehensive assessment upon admission.On [DATE] at 11:05 AM, wound care progress notes by MD Z stated R43 returned from hospital with a Stage 4 pressure wound of the left heel. Left heel measures 3.5 cm long x 7 cm wide x 1.3 cm deep. MD Z's treatment orders are primary dressing Hydrofera blue apply once daily and as needed. For 8 days, Collagen powder apply once daily and as needed. For 30 days, Hypochlorous acid solution (vashe) apply once daily and as needed.On [DATE], R43 had an additional wound care order from the hospital, which stated Tobramycin Sulfate Injection solution [antibiotic used to treat serious bacterial infections], apply to left heel topically two times a day for wound care.Progress notes from MD Z dated [DATE], [DATE], and [DATE] indicated no change in treatment orders and R43's left heel wound continued to improve and decrease in size.On [DATE] at 12:30 PM, an SBAR was completed on R43 related to change in condition. SBAR documents Blood Pressure 145/65, Pulse 111, Respirations 22 per minute, oxygen saturation 98%, Blood Sugar 162 mg/dl/ States R43 weak, has a bloody nose. R43 seen by Nurse Practitioner (NP).On [DATE] at 7:04 PM, R43's progress note from MD Z stated, this (wound) has been gently packed, and the patient is going to be sent to the ER for chills and rigors possibly due to sepsis. The note states the patient [R43] appears to be septic with tachypnea and tachycardia. The source is unknown at this time, but it was felt that a rapid workup could not be done at the facility so he [R43] can be sent to the emergency room for treatment and workup.On [DATE] at 2:50 PM, Surveyor called hospital SW BB, who reported R43 has since been admitted to the hospital with sepsis and needed to be transferred to a higher level of care for treatment of sepsis. On [DATE] at 1:10 PM, Surveyor interviewed MD Z, who reported he felt R43's wounds were improving and that R43 was hospitalized due to urosepsis.On [DATE] at 1:00 PM, Surveyor reviewed R43's hospital discharge record, which indicated R43 was hospitalized for sepsis secondary to streptococcus dysgalactiae bacteremia-left calcaneal osteomyelitis (a left heel infection). Hospital noted as diagnosis this was an open wound of the left heel, and pressure injury of the left heel, stage 4. Hospital records state the podiatry clinic was consulted and due to R43's comorbidities, R43 would be discharged to facility with IV (intravenous) antibiotics first. Records indicate that a biopsy followed by cutting half of R43's heel may result in loss of mobility for a long time and R43 will also need extensive wound care including wound VAC etc. R43 may not heal well after the procedure; it may interfere with quality of R43's life given multiple comorbidities. Podiatry recommended against procedure and try IV antibiotics with goals of care discussion.On [DATE] at 2:37 PM, R43 was readmitted to the facility following hospitalization.On [DATE] at 9:20 AM, Surveyor interviewed DON J, who agreed wound care orders from MD Z were not followed and R43's care plan was not updated. DON J also agreed that the expectation of the facility staff would be R43's wound care treatment orders be followed, completed, and documented by facility nurses, and R43's care plan been updated to address changes and new interventions. DON J stated the comprehensive wound assessments were performed by MD Z and that is why there is not documentation of comprehensive wound care assessment by facility nurses.On [DATE] at 11:04 AM, Surveyor interviewed NHA A via telephone and asked why the facility did not complete comprehensive assessments on R43 with development of the new PI on the heel, changes in treatments for the PI, and for ensuring wound is observed for changes between the weekly wound MD visits. NHA A stated the facility doesn't do comprehensive (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	assessments. NHA A stated they fill out the SBAR if there is a change in the residents. Surveyor stated to NHA A that there was only one SBAR that was completed on R43 dated [DATE] at 2:30 PM, documenting a new PI on the left heel with only measurements and that PI was wrapped and pressure boots applied to feet when R43 is in bed. NHA A did not have any further information.On [DATE] at 12:41 PM, Surveyor received a summary of R43's treatment progress from MD Z. The email concludes its review of R43's care by noting: On [DATE], MD Z's progress note states: Pt. [R43] brought to ER for acute abdominal pain, diagnosed with acute cholecystitis; hospital record denotes history of (h/o) peripheral artery disease (PAD), diabetes mellitus (DM),chronic kidney disease (CKD), describes L heel ulcer status post (s/p) recent debridement; heel ulcer treated with antibiotic (Abx), noted that hospital discharge summary recommends out-patient follow-up with no indication of urgent wound debridement requiring transfer, as patient has remained vitally stable.On [DATE], MD Z's progress note states: Pt. [R43] seen at facility by [name of physician] reports feeling well, L heel wound much improved. MD Z's treatment progress goes on to say that comprehensive clinical diagnosis and intraoperative wound debridement were performed during his hospitalization of [DATE] to [DATE], and specialty out-patient recommendations continued thereafter, the clinical impression is that these unfortunate complications appear to have developed despite appropriate and consistent out-patient care at [name of facility], on the basis of chronicity of this gentleman's [R43's] wound and co-morbidities; (documentation supporting the above has been submitted, i.e. Unavoidable Pressure Injury criteria). Surveyor, however, notes the facility did not conduct comprehensive assessments of R43 with the development of the left heel PI, nor conduct comprehensive assessments of R43 to note any changes in the PI in between the weekly MD visits for wound care, did not implement new interventions for R43 to prevent further development of PIs, and failed to ensure treatment orders were transcribed and followed as per physician orders. This PI deteriorated to a stage IV with osteomyelitis, which required hospitalization and IV antibiotics.The facility's failure to implement aggressive interventions to prevent PI development, ensure treatment orders were completed as ordered and complete a comprehensive assessment upon discovery of a new left heel PI created a reasonable likelihood for serious harm which led to a finding of immediate jeopardy. R43 developed an avoidable PI which deteriorated to a stage IV with osteomyelitis requiring IV antibiotics. The facility removed the immediate jeopardy on [DATE], when it completed the following:Facility initiated education for all licensed nursing staff (RNs and LPNs) immediately upon IJ notification and completed prior to the next scheduled shift including:Prompt identification and reporting of new pressure injuries.Completion of comprehensive assessments upon discovery of a new PI.Completion of daily diabetic foot checks.Accurate transcription, initiation, and completion of physician ordered treatments.Implementation of aggressive PI prevention and treatment interventions per standards of practice.Education on notification of physician/np of all new PI as well as any significant changes to PI.Licensed nursing staff completed competency validation related to PI staging and documentation, treatment application per physician orders, and heel offloading, repositioning, skin protection, and preventive interventions.Facility conducted skin assessments and Braden scale assessments of all residents in the facility.Facility conducted TAR audits of residents to ensure wound treatments were completed as ordered.Facility reviewed resident wound treatment orders to ensure they were accurate and appropriate.Facility conducted wound round audits on all residents with wounds/PIs.The deficient practice continues at a scope/severity level E (potential for more than minimal harm that is not immediate jeopardy/pattern) as the facility continues to implement its action plan.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure a resident's environment remains free of accident hazards and each resident receives adequate supervision and assistive devices to prevent accidents for 2 of 4 residents (R3 and R50) reviewed. -R3 was assessed as an elopement risk and care planned to have a wanderguard on her left wrist. It was observed R3 did not have a wanderguard on. -R50 was observed being transferred without a gait belt as care planned.Example 1 The facility policy titled, Wandering, Unsafe Resident, read in part, 1. The staff will identify residents who are at risk for harm because of unsafe wandering (including elopement). 3. The resident's care plan will indicate the resident is at risk for elopement or other safety issues. 4. Interventions to try and maintain safety will be included in the resident's care plan.R3 was admitted to the facility on [DATE] with diagnoses including anxiety, depression, and dementia. On 12/17/25, a Minimum Data Set (MDS) assessment confirmed R3 scored 5/15 during Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment. On 10/18/25, an elopement assessment was completed on R3 and noted R3 to be an elopement risk and continue with wanderguard to left wrist. R3's physician orders included: -Check skin around wanderguard every shift, 04/18/25. R3's care plan included: -Elopement/wanderer risk related to history of attempts to leave the facility unattended. History of removing wanderguard, 04/21/25. Wandering device to LEFT wrist. Check placement and function, revised 08/25/25. Surveyor reviewed R3's Treatment Administration Record (TAR) for December 2025 and January 2026. Surveyor noted nursing staff documenting daily on AM and PM shifts to check skin around wanderguard every shift, and wanderguard to left wrist expiration date 11/27/25-check placement and function every shift. On 01/12/26 at 9:46 AM, Surveyor interviewed R3. Surveyor observed R3 did not have a wanderguard on her left wrist. R3 stated, Why would I have one of those on? R3 denied any attempts to leave the facility unattended. Surveyor reviewed the elopement binder located at the nurses' station. Surveyor noted R3 was listed as an elopement risk, with wanderguard placed to left wrist, expiration date of 11/27/25. On 01/12/26 at 10:10 AM, Surveyor interviewed Licensed Practical Nurse (LPN) S. Surveyor noted LPN S documented in R3's TAR she had checked R3's wanderguard. LPN S stated, The last time I checked she had it on. LPN S was unable to tell Surveyor when she last noted R3's wanderguard. LPN S told Surveyor maybe it was not on R3's wrist but her ankle. On 01/12/26 at 10:15 AM, Surveyor interviewed Certified Nursing Assistant (CNA) T. CNA T stated she (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	did not think R3 had a wanderguard on. CNA T reported she has taken R3 out to smoke and the alarm has not gone off. CNA T stated she would remember if R3's wanderguard triggered the alarm. On 01/12/26 at 10:36 AM, Surveyor observed R3's left ankle, and noted R3 did not have a wanderguard on. R3's right leg was amputated below the knee. On 01/12/26 at 1:30 PM, Surveyor interviewed Director of Nursing in training (DON) C. DON C and Surveyor observed R3 did not have a wanderguard on her body or her wheelchair. DON C stated she would look into it. On 01/13/26, DON C reported the Assistant Director of Nursing stated she observed R3's wanderguard on her wrist on 01/12/26. Observations and interviews on 01/12/26 do not support R3 had a wanderguard on 01/12/26. On 01/13/26 at 2:28 PM, Surveyor interviewed CNA U. CNA U stated she is unsure if R3 has had a wanderguard on. CNA U stated, Not that I know of. Example 2 The facility policy, titled Safe lifting and Movement of Residents provided to Surveyor states: Policy Statement: In order to protect the safety and well-being of staff and residents, and to promote quality care, this facility uses appropriate techniques and device to lift and move residents. Under section titled Policy Interpretation and Implementation: states in part: staff will be trained in the use of manual (.gait/transfer belts). R50 was admitted to facility on 12/28/24 and has an activated power of attorney (POA). R50's significant change in condition MDS dated [DATE] indicated R50 has a BIMS score of 05 (Moderately impaired) and requires substantial/maximal assistance for toilet transfers. R50's care plan approach initiated 02/03/2025 states, Two person transfer with [NAME] Belt. On 01/11/2026 at 1:59 PM, Surveyor observed R50 sitting on toilet under supervision of CNA T and noted no gait belt around R50's waist. Surveyor continued to observe CNA T conduct incontinence care and transfer R50 into wheelchair independently and without use of a gait belt. After observation of transfer, Surveyor asked CNA T the facility's expectation for safe transfers. CNA T stated has not being using a gait belt for R50's transfers and checked R50's care plan and stated that care plan does not indicate to use a gait belt for transferring.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review, the facility did not ensure a registered nurse (RN) worked at the facility for at least eight (8) consecutive hours a day, seven days a week, on 3 of 92 days reviewed. This deficient practice had the potential to affect all 47 residents.The facility was unable to provide documentation to support that an RN was working in the facility for at least 8 consecutive hours on 08/15/25, 09/08/25, and 09/09/25.This is evidenced by:Surveyor reviewed the PBJ Staffing Data Report for fiscal year Quarter 4 2025 (July 1 - September 30) which triggered for 4 or more days within the quarter with no RN hours on 08/15/2025, 09/08/25, 09/09/25 and 09/14/25.Surveyor reviewed the facility staff scheduled and nurse posting for the last 92 days of Quarter 4 2025 (July 1- September 30). Surveyor noted on 08/15/2025 (Friday), 09/08/25 (Monday), and 09/09/25 (Tuesday) there was not an RN scheduled for 8 consecutive hours. On 01/14/26 at 10:05 AM, Surveyor interviewed Nursing Home Administrator (NHA A) and the Assistant Nursing Home Administrator (ANHA B) regarding the facility PBJ Staffing report for fiscal year quarter 4 (July 1 - September 30).On 01/14/26 at 10:40 AM, Surveyor interviewed NHA A and ANHA B regarding the facility's daily staff posting process who indicated the receptionist will post the staff posting in the mornings after updating the census and that the facility not manually update the posting but reflect changes on schedule which is not posted for the public.On 01/14/2026 at 1:24 PM, Surveyor received documentation to support RN coverage on 09/14/25 from ANHA B who stated that during the time period of on 8/15/25 - 0/9 /14/25, corporate RNs were doing a rotating schedule for the 8 hours required coverage but was unable to provide further documentation to support RN coverage for 08/15/2025, 09/08/25, and 09/09/25.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on interview and record review, the facility did not ensure staff postings were posted daily and included total number of hours and actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care per shift which has the potential to affect 47 out of 47 residents residing at the facility.Review of staff postings did not reflect the accurate staffing numbers each day.On 01/11/2026 at 9:07 AM, upon entrance to facility Surveyor noted the Facility's Direct Care Report posted in lobby dated December 19, 2025: Census 47. On 01/13/2026, Surveyor received and reviewed the facility's schedules and staff postings from 12/01/25 through 01/13/26 and noted: Print date and actual time stamped at bottom of each page for time frame.Staff schedules were marked with changes on 12/16/25, 12/26/25, 12/29/25, 12/31/25, 01/01/26, 01/03/26, 01/04/26, 01/06/26, 01/11/26, 01/12/26, and 01/13/26.Staff posting did not reflect the accurate staffing numbers for 01/01/26, 01/03/26, 01/02/26, 12/16/25, 12/29/25, 12/31/25.On 01/14/26 at 10:40 AM, Surveyor interviewed Nursing Home Administrator (NHA) A and Assistant Nursing Home Administrator (ANHA) B asking what the facility daily staff posting process is. NHA A indicated the receptionist will post the staff posting in the mornings after updating the census. The daily posting is not updated manually, but any changes are reflected on the daily schedules.