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	03/18/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview, and record review, the facility did not treat each resident with respect and dignity and care for each resident in a manner that promotes their quality of life. This occurred for 2 of 2 residents (R3 and R29).R3 and R3's representative were not informed of audio and visual surveillance that had been placed in his room for his roommate, R29.R3 and R29, or their resident representatives, did not consent to the audio and visual surveillance.R3 was admitted to the facility on [DATE], after a hospitalization for altered mental status and falls at home.R3's Brief Interview for Mental Status (BIMS) confirmed R3 scored 08/15, indicating moderate cognitive impairment. R3 was appointed a guardian to assist with decision making.R3 was admitted to a room with R29. Prior to R3's admission, R29's activated power of attorney (POA) had placed a video monitoring camera in R29's room. R29's POA has access to observe both video and audio surveillance. The facility does not have access to the surveillance.On 03/17/26 at 1:18 PM, Surveyor observed placement of camera, on the right side of the room, atop R29's closet and pointed to the corner of R29's room. The camera was not in line of sight of the doorway, hallway, or R3's side of the room.On 03/17/26 at 1:30 PM, Surveyor interviewed R3. R3 stated he was aware there was a camera in the room and pointed above the doorway. Surveyor told R3 there was not a camera in the area where R3 was pointing. During conversation with R3 it was noted R3 was not answering questions appropriately.Surveyor reviewed R3's record and could not find evidence R3 or his guardian consented to the camera in R3's room. Surveyor could not find documentation R3 was made aware there was a camera in the room.Surveyor reviewed R29's record and noted there was no consent for the camera in R29's room.Surveyor reviewed R3 and R29's care plans and noted there was no care plan for the video surveillance in R3 and R29's room.On 03/17/26 at 3:04 PM, Surveyor interviewed R3's guardian. R3's guardian reported she was not aware there was a camera in the room R3 was residing in. R3's guardian reported she was not comfortable with a camera being in the room.On 03/17/26 at 3:52 PM, Surveyor interviewed Nursing Home Administrator (NHA) A. NHA A reported the camera in R29's room does have volume, so R29's family would be able to hear conversations in R3 and R29's room. This would include any conversations R3 may have in his room.NHA A reported Social Services Director (SSD) C discussed this with R3's guardian at a care conference and stated this was not documented in R3's record. Surveyor was unable to find documentation this was discussed at a care conference in R3's record.NHA A provided Surveyor with an email chain from January 2026, including SSD C and R29's POA, indicating the need to sign a consent for the camera. R29's record did not include a consent for the camera. Surveyor understands this was discussed with R29's POA; however, the facility did not obtain the consent.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure care plans were revised to reflect residents' current needs and to provide the needed direction to staff in providing necessary care and services. The facility practice affected 1 of 4 resident (R2) care plans reviewed.The facility did not revise R2's care plan after each fall. R2 was admitted to the facility on [DATE] after a hospitalization for increased confusion and falls at home. An elopement assessment was conducted on 02/05/26 and indicated no elopement risk. A fall assessment was conducted on 02/05/26 and indicated low fall risk.R2 scored 08/15 during Brief Interview for Mental Status (BIMS), indicating moderately impaired cognition. R2's power of attorney (POA) was activated to assist with decision making.Surveyor reviewed R2's record and noted the following falls:-02/14/26, fall with major injury. Sent to ER and hospitalized for fractured pelvis.-02/18/26, fall in room. New intervention on eINTERACT form, Call for Help sign.-02/21/26, fall in room. New intervention on eINTERACT form, remove walker when in bed and place wheelchair at bedside.R2's care plan included:-Increased risk for falls related to deconditioning due to ataxia, recent fall, muscle weakness unwitnessed fall 02/18/2026, noncompliant with transfer assistance. Date Initiated: 02/05/2026 Revision on: 03/16/2026.-Interventions: Call light is within reach and encourage the resident to use it for assistance as needed. Date Initiated: 02/05/2026.-Interventions: Therapy evaluate and treat as ordered or PRN. Date Initiated: 02/05/2026.On 03/18/26 at 9:20 AM, Surveyor observed R2's room. Surveyor observed a call for help sign placed on the wall next to R2's bed, and R2's walker was placed near her closet. R2 was not in her room at the time of the observation.On 03/18/26 at 9:30 AM, Surveyor interviewed Certified Medication Assistant (CMA) E. CMA E reported R2's fall interventions were to toilet her after each meal and a floor mat next to her bed. CMA E reported staff can find interventions in the resident's care plan or it is communicated during shift-to-shift report.On 03/18/26 at 9:35 AM, Surveyor interviewed Certified Nursing Assistant (CNA) F. CNA F reported R2 uses her wheelchair for mobility and has recently been approved by physical therapy to ambulate with staff with walker and gait belt. CNA F stated she was aware R2 was a fall risk, and the interventions were to put R2's bed in the lowest position. CNA F reported fall interventions could be found in the resident's care plan.On 03/18/26 at 9:40 AM, Surveyor interviewed Physical Therapy Assistant (PTA) G. PTA G confirmed R2 has been in therapy since her admission on [DATE]. R2 was reevaluated for continuing therapy due to her fall with injury. PTA G confirmed R2 was doing well in therapy and was able to ambulate with walker and assistance. PTA G was aware R2 was a fall risk and stated R2 self-transfers frequently. PTA G stated the facility does not use alarms and was unsure if therapy had made any recommendations related to R2's fall risk, as R2 was currently still in therapy.On 03/18/26 at 10:00 AM, Surveyor interviewed Director of Nursing (DON) B. DON B confirmed she was present the day R2 eloped. DON B confirmed she assessed R2 outside, stating R2 complained of knee pain and R2's ROM was within normal limits. DON B stated her and three staff assisted R2 into a wheelchair as it was not safe to use the Hoyer lift outside where there was snow and ice. DON B reported that R2 did not complain of pain until she was brought into the building. DON B stated she called the on-call provider and obtained order to send R2 the ER.DON B reviewed R2's care plan and noted fall interventions were not added to R2's care plan after her falls. DON B provided Surveyor with eINTERACT forms, which are also in R2's progress notes, indicating the fall interventions that were added after each fall. DON B confirmed it is the nurses' responsibility to add the interventions to the care plan after completing the eINTERACT form. DON B stated she had begun immediate education with licensed nursing staff, as the nurses were not aware they were to update the care plan.Surveyor determined the facility did not revise R2's care plan to reflect the current interventions in place to reduce her fall risk.