STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525680	A. Building B. Wing	09/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
United Pioneer Home	623 S Second St Luck, WI 54853

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility did not ensure food was stored and prepared in a sanitary manner that prevents foodborne illness to the residents. This practice had the potential to affect all 40 residents within the facility.*Open food noted in cold storage, not labeled and dated.*Cook D did not have a hair net on mustache. Findings:Labeling open foods:The 2022 FDS Food Code documents at 3-501.18 Ready-to-Eat, Time/Temperature Control for Safety Food: Disposition .A date marking system may be used which places information on the food, such as on an overwrap or on the food container, which identifies the first day of preparation, or alternatively, may identify the last day that the food may be sold or consumed on the premises. A date marking system may use calendar dates, days of the week, color coded marks, or other effective means, provided the system is disclosed to the Regulatory Authority upon request, during inspections.On 09/22/2025 at 8:33 AM, during initial tour of the kitchen, Dietary Director (DD) C provided Surveyor with a tour of the cold storage items. In the refrigerator was an open gallon of milk without an opened date written on it. In the frozen storage Surveyor showed DD C an open bag of hashbrowns, frozen peas and peas and carrots with no opened date written on them. DD C replied, That should have a date on them; we will discard these unmarked items.On 09/23/2025 at 11:35 AM, Surveyor observed [NAME] D obtaining temperatures on hot food items before serving lunch on the Harmony unit. [NAME] D was noted to have black facial hair greater than one quarter inch for both his beard and mustache. [NAME] D had a hair restraint on the top of his head and a beard restraint on his chin, but the restraint did not cover his mustache.On 09/23/2025 at 11:40 AM, Surveyor noted that [NAME] D was now temping foods on the Butternut unit. [NAME] E did not have his mustache covered on that unit either.On 09/24/2025 at 9:10 AM, Surveyor interviewed Dietary Director (DD) E regarding the observations made of [NAME] D temping food with a beard restraint not covering his mustache. DDE replied, All facial hair must have a hair restraint when serving food to the residents.

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 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 were notified of the rate to reserve the resident's bed in the bed hold notice. This has the potential to affect 2 of 5 residents R9 received bed hold notices with no daily rate documented and no information on resident appeal rights. R5 received bed hold notices with no daily rate documented and no information on resident appeal rights. R3's bed hold notices did not have daily rate documented and no information on resident appeal rights. R15 received a verbal bed hold notice, but facility did not have any documentation that R15 received the daily rate or information on resident appeal rights. R16 received a bed hold notice but it did not have the daily rate documented nor information on resident appeal rights. Findings: Example 1 R9 was admitted to the facility on [DATE], with a Brief Interview of Mental Status (BIMS) score of 10/15, which indicated that R9 was cognitively intact. R9 had diagnoses of dementia, chronic obstructive pulmonary disease (COPD,) and history of urinary tract infection (UTI.) R9 had a care plan for confusion due to dementia, hypoxia related to COPD and UTI symptoms dated 3/13/25. R9 had a Minimum Data Set (MDS), dated [DATE], titled Discharge Return Anticipated. On 05/23/25, progress note revealed R9 became confused and unresponsive. R9 left the facility by ambulance and went to the emergency room. On 09/23/2025 at 12:13 PM, Surveyor interviewed Director of Nursing (DON) B and requested bed hold notices for R9's hospitalization. On 09/23/2025 at 2:28 PM, DON B provided Surveyor with bed hold notice and indicated they do not have a dollar amount on them informing R9 of the exact amount R9 would be charged. Surveyor reviewed bed hold notices and noted there is no statement of resident's appeal rights. On 09/23/2025 at 2:52 PM, Surveyor informed DON B and Nursing Home Administrator (NHA) A that there is no dollar amount on R9's bed hold form and the bed hold has no appeal rights for the residents. DON B responded that facility will update form to include that information (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Example 2 R5 was admitted to the facility on [DATE], with a Brief Interview of Mental Status (BIMS) score of 10/15, which indicated that R5 was cognitively intact. R5 had diagnoses of vascular dementia, Parkinson's disease, congestive heart failure, atrial fibrillation, and history of urinary tract infection. R5 had a care plan for quality of life care dated 5/5/25. R5 had an MDS, dated [DATE], titled Discharge Return Anticipated. On 05/15/25, progress note revealed R5's breathing was labored and reported chest discomfort with symptoms of pneumonia. R5 left the facility by ambulance and went to the emergency room. On 09/23/2025 at 12:13 PM, Surveyor interviewed DON B and requested bed hold notices for R5's hospitalization. On 09/23/2025 at 2:28 PM, DON B provided Surveyor with a bed hold notice and indicated they do not have a dollar amount on them informing R5 of the exact amount R5 would be charged. Surveyor reviewed bed hold notices and noted there is no statement of resident's appeal rights. On 09/23/2025 at 2:52 PM, Surveyor informed DON B and NHA A that there is no dollar amount on R5's bed hold and the bed hold has no appeal rights for the residents. DON B responded that facility will update form to include that information Example 3 Resident (R) 3 was admitted to the facility on [DATE]. R3 had Minimum Data Set (MDS) discharge return anticipated, dated 06/12/25, 08/29/25, and 09/14/25. On 09/23/2025 at 12:13 PM, Surveyor requested from Director of Nursing (DON) B bed hold notices for all three of these hospitalizations. On 09/23/2025 at 2:28 PM, DON B provided Surveyor with bed hold notices and indicated they do not have a dollar amount on them informing R3 of the exact amount R3 would be charged. Surveyor reviewed bed hold notices and noted there is no statement of resident's appeal rights. On 09/23/2025 at 2:52 PM, Surveyor informed DON B and NHA A that there is no dollar amount on the bed hold and the bed hold has no appeal rights for the residents. DON B replied, We will fix that. Example 4 On 09/22/25 at 1:46 PM, Surveyor reviewed R15's two hospitalizations, dated 04/25/25 and 08/19/25. Surveyor did not find documentation that R15 received written notification of a bed hold or was informed in writing of the daily bed hold rate until R15 returns to facility. On 09/23/25 at 2:16 PM, Surveyor interviewed DON B and asked DON B if R15 had a bed hold given to them. DON B reported back to Surveyor that R15 was told verbally about bed hold. DON B provided Surveyor with progress note stating that bed would be held but Surveyor did not see that the progress note stated how much the daily rate was for bed hold or inform resident or representative in writing of (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident's rights pertaining to bed hold. Example 5 On 09/22/25 at 1:53 PM, Surveyor reviewed R16's hospitalization dated 04/25/25. Surveyor found documentation that R16 received written notification of a bed hold but was not informed of the daily bed hold rate or R16's resident rights that should be stated on the bed hold form. On 09/23/25 at 2:16 PM, Surveyor interviewed DON B and asked DON B if R16 had a bed hold given to them. DON B reported back to Surveyor that R16 was given a bed hold form. DON B provided Surveyor with bed hold form, but Surveyor did not see that the bed hold form stated how much the daily rate was for bed hold or inform resident or representative in writing of resident's rights.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview and record review, the facility did not establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. This affected residents (R) R29, R41, R17, R16, R21, and R15. Certified Nursing Assistant (CNA) G did not perform hand hygiene when passing water pitchers to R29, R41, R17, R16, and R21. CNA H did not perform hand hygiene when providing peri cares to R15. Maintenance F entered R16's droplet precaution room without donning PPE when cleaning R16's room. Findings include: The facility policy titled Transmission Based Precautions dated last review March 2025, in part reads: .Contact Precautions: #2. Wear gloves when entering room. Wear gown when contact with the resident or potentially contaminated surfaces in their environment will occur.Droplet Precautions: #2. In addition to contact precaution measures, a mask shall be donned when entering the room for contact within 6 feet for the resident. Surveyor requested and reviewed the facility policy titled Hand Hygiene dated March 2025. The policy in part reads: .#8. Use alcohol-based hand rub containing at least 62% alcohol, or alternately, soap and water for the following situations: h. Before moving from a contaminated body site to a clean body site during resident care. J. After contact with bodily fluids.Example 1On 09/23/2025 at 10:41 AM, Surveyor observed CNA G passing water pitchers to residents. Surveyor observed CNA G enter R29's room. CNA G placed clean water pitcher on R29's bedside table. Surveyor observed CNA G take R29's dirty water pitcher and place it on the clean water cart. Surveyor did not observe CNA G sanitize hands when exiting R29's room. Surveyor observed CNA G grab a clean pitcher with contaminated hands and enter R41's room. CNA G placed the clean water pitcher on R41's bedside table. Surveyor observed CNA G take R41's dirty water pitcher and place it on the clean water cart. Surveyor did not observe CNA G sanitize hands when exiting R41's room. Surveyor observed CNA G grab a clean pitcher with contaminated hands and enter R17 's room. CNA G placed clean water pitcher on R17's bedside table. Surveyor observed CNA G take R17's dirty water pitcher and place it on the clean water cart. Surveyor did not observe CNA G sanitize hands when exiting R17's room. Surveyor observed CNA G grab a clean pitcher with contaminated hands and entered R16's droplet precaution room. CNA G placed clean water pitcher on R16's bedside table. Surveyor observed CNA G take R16's dirty water pitcher and place it on the clean water cart. Surveyor did not observe CNA G wearing Personal Protective Equipment (PPE) when entering or sanitizing hands when exiting R16's precaution room. Surveyor observed CNA G ambulate down hallway to kitchen and drop off dirty water pitchers. Surveyor observed a call light going off in R21's room. CNA G sanitized hands then and entered R21's room. On 09/23/25 at 10:52 AM, Surveyor interviewed CNA G and asked what CNA G's process is when passing water pitchers to residents to practice infection control and prevent the spread of infections. CNA G reported that CNA G should have sanitized hands in between residents' rooms and understands that CNA G did not. On 09/23/25 at 3:32 pm, Surveyor interviewed Director of Nursing (DON) B and asked DON B what DON B's expectations are for sanitizing hands during water pass and grabbing used dirty water pitchers from residents' rooms. DON B reported to Surveyor that DON B expects CNA G to sanitize hands in between each resident's room before grabbing clean pitchers and delivering them. DON B reported to Surveyor that all staff should be sanitizing hands before entering residents' rooms and after leaving residents' rooms. Example 2On 09/22/2025 at 10:53 AM, Surveyor entered R15's room and observed R15 on toilet in bathroom with call light going off. Surveyor observed CNA H enter R15's room and place gloves on. CNA H walked over to toilet and began wiping R15 with wipes. Surveyor observed CNA H finish cleaning R15's bowel movement (BM) off R15's bottom. CNA H then proceeded to pull R15's brief and pants up with contaminated gloves. CNA H then assisted R15 to walker and walked out of bathroom with contaminated gloves. Surveyor observed CNA H grab R15's wheelchair and began transferring R15 to the wheelchair with contaminated gloves. Surveyor observed CNA H rearrange oxygen tubing from (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	underneath wheelchair wheels with contaminated gloves. Surveyor observed CNA H grab nasal cannula with contaminated gloves and placed into R15's nose. Surveyor observed CNA H place R15's jacket over R15's shoulders with contaminated gloves. Once CNA H was done assisting R15 in R15's room, CNA H doffed contaminated gloves in trash and continued to push R15 out of R15's room to the reading activity in lounge. Surveyor did not observe CNA H sanitize contaminated hands. Surveyor observed CNA H park R15 in wheelchair in the lounge and then walked over to a resident and touched her back to say hello with contaminated hands. On 09/22/2025 at 10:59 AM, Surveyor interviewed CNA H and asked what CNA H's process is for sanitizing hands and changing contaminated gloves. CNA H reported that CNA H should have taken off contaminated gloves after wiping BM off R15 before touching any other surfaces. CNA H apologized to Surveyor. On 09/23/25 at 3:35 pm, Surveyor interviewed DON B and asked what DON B's expectations are for doffing contaminated gloves and sanitizing hands before and after toileting R15 before providing other cares. DON B reported to Surveyor that DON B expects CNA H to doff contaminated gloves after providing peri cares and sanitize hands before providing any other cares to R15 per facility policy. Example 3On 09/23/25 at 11:02 AM, Surveyor observed Maintenance F enter R16's droplet precaution room without donning gown. Maintenance F started cleaning R16's surfaces in droplet precaution room. Maintenance F cleaned bathroom, bedside table surfaces, and floors while in R16's room without PPE gown on. On 09/23/25 at 11:10 AM, Surveyor interviewed Maintenance F and asked what Maintenance F's process is for cleaning transmission-based rooms. Maintenance F reported to Surveyor that Maintenance F reviews the sign on door before entering and makes sure to don appropriate PPE per the isolation requirements. Surveyor asked Maintenance F what PPE is to be utilized in R16's droplet precaution room. Maintenance F reported to Surveyor that he wore gloves and mask. Surveyor asked Maintenance F why Maintenance F did not also don a gown for droplet precautions. Maintenance F reported that if R16 is not in room then Maintenance F does not have to wear gown while cleaning R16's surfaces. On 09/23/25 at 3:37 PM, Surveyor interviewed DON B and asked DON B's expectations for Maintenance F donning PPE in droplet precaution room for R16. DON B reported that all staff need to be following the isolation signs outside the door. DON B reported droplet precautions act like contact precautions and when any staff are within 6 feet from R16 or near high contact surfaces, that all PPE is to be utilized such as mask, gloves, and gown.

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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 the resident's environment remains as free of accident hazards as possible. The facility did not use appropriate assist devices during transfer when needed to prevent accidents which affected resident (R) (R6).Certified Nurse Assistant (CNA) H did not use gait belt while transferring R6 from toilet to wheelchair.Findings include:Facility policy titled, Fall Protocol, dated reviewed in February 2025, states in part: .Definition: A fall refers to unintentionally coming to rest on the ground, floor, or other lower level. An episode where resident lost his/her balance and would have fallen, if not for staff intervention, is considered a fall. Facility policy titled, Safe Resident Handling, dated reviewed in September 2017, states in part: .#5. Direct resident care staff will avoid manually lifting residents except for medical emergencies.#7. Suggested patient/resident handling aids: Minimal assist: The resident is ambulatory, able to assist, has a steady gait, and will follow directions, but may have some periods of confusion. Use transfer aids and gait belt.R6 was admitted to the facility on [DATE], with following diagnoses, in part, osteoarthritis left knee, polymyalgia rheumatica, muscle wasting, bursitis of left knee, weakness, atrial fibrillation, anemia, and adult failure to thrive.R6's Activities of Daily Living (ADL)s care plan states:-TRANSFER: Independent in the facility with FWW [four-wheeled walker] revised on 09/26/24.-AMBULATION: Independent in facility with FWW revised on 09/26/24.-AMBULATION: CGA [contact guard assist] x1 in facility with FWW revised on 12/30/24.AMBULATION: CGA x1 with gait belt in facility with FWW revised on 03/27/25.R1's fall care plan states:-Ambulation: Does not ambulate. Power w/c [wheelchair] to all destinations.-Bed mobility: Assist of one. -Transfer: Pivot contact guard assist of one with gait belt. EZ-Stand as needed with assist of one.On 09/23/25 at 10:15 AM, Surveyor observed R6 wanted to lay down in bed after using the toilet. CNA H assisted R6 with getting off the bathroom toilet. Surveyor observed R6 stand at the toilet using the assist bars to help stand. Surveyor did not observe CNA H place a gait belt on R6. CNA H was cleaning R6's bottom with wipes when R6 screamed, I can't stand long. Surveyor observed R6's legs give out and R6 plopped on the toilet seat hard falling backwards into toilet railing. Surveyor observed CNA H try to grab R6 but couldn't grab onto anything. R6 reported that her left leg is giving her pain still and it hurts bad. CNA H instructed R6 to try and stand again. Surveyor did not observe CNA H place gait belt on R6 at this time. R6 attempted to stand again allowing CNA H to finish cleaning R6 and pulling pants up. R6 then quickly pivoted and plopped herself in wheelchair landing on the edge of R6's wheelchair seat. R6 raised R6's voice and stated to CNA H, I need my wheelchair foot plate pushed down fast. I am slipping out of the wheelchair. CNA H told R6 to calm down and proceeded to move R6's feet to place foot plate down. R6 yelled that R6 was going to slip out of the wheelchair as R6 is on the edge if CNA H continues to do that. R6 then stated, Hurry, I need the foot plate down soon. CNA H adjusted the foot plate and R6 was able to boost self in wheelchair. CNA H propelled R6 over to the bed and stand pivoted R6 from wheelchair to bed without gait belt in place. Surveyor observed CNA H finish with R6 and exit R6's room. On 09/23/25 at 10:23 AM, Surveyor interviewed CNA H and asked CNA H what CNA H's process is for safe transfers with R6 when R6 is feeling weak. CNA H reported to Surveyor that CNA H should have been using a gait belt but sometimes R6 is in a rush to get going on whatever R6 is doing. On 09/23/25 at 3:31 PM, Surveyor interviewed Director of Nursing (DON) B and asked DON B what expectations are for transferring R6 from wheelchair to toilet and from toilet to wheelchair. DON B reported that R6 is an assist of one and needs help in bathroom. Surveyor asked DON B if it is the expectation that CNA H uses a gait belt when transferring R6 as one assist from wheelchair to toilet and toilet to wheelchair. DON B reported to Surveyor that usually staff follow whatever the care plan is, but facility policy states anyone who is independent with transfers does not need a gait belt but all other transfers including assist of one and above need gait belts for safety.

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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, interview and record review, the facility failed to ensure standards of practice were followed for providing respiratory services for 1 of 1 resident (R) reviewed for oxygen therapy (R15). Certified Nurse Assistant (CNA) H did not check portable oxygen tank before taking R15 to lounge for an activity according to facility policy. The facility did not implement new respiratory interventions after each episode of R15 found with no oxygen on. Findings include:Surveyor reviewed the facility protocol titled Oxygen Therapy, last reviewed in April 2019, states in part, .initiating oxygen: 2. Turn on the oxygen to the prescribed flow rate. 3. Place appropriate oxygen to device on the resident (i.e., mask, nasal cannula and/or nasal catheter). 5. Check the mask, tank, humidifying jar, etc., to be sure they are in good working order and are securely fastened. 6. Observe the resident upon setup and periodically thereafter to be sure oxygen is being tolerated. R15 was re-admitted to the facility on [DATE], with following diagnoses, in part, unspecified fracture of lower end of right humerus, respiratory failure with hypoxia, pan lobular emphysema, heart failure, atherosclerosis of coronary artery bypass graft, atrial fibrillation, cardiac pacemaker, and muscle weakness. R15's oxygen therapy related to congestive heart failure care plan initiated on 04/24/25 and revised 05/08/25 states: The resident will have no signs and symptoms of poor oxygen absorption through the review date. -Promote lung expansion and improve air exchange by positioning with proper body alignment. If tolerated, head of bed elevated to approximately 30 degrees revised on 05/15/25.-Oxygen settings: O2 [oxygen] via nasal cannula at 2-4L [liters]. May titrate to keep O2 above 89%. Update provider for need to titrate in O2 requirement above 4L revised on 08/13/25.-Ensure nasal canula is properly in nares throughout shift, as it is known to shift out of place initiated on 09/22/25. Surveyor reviewed R15's progress notes, which state in part: .-On 05/28/25 at 11:49 PM, Administration note: Apply O2 continuously via nasal cannula to keep O2 saturations 90% or greater; 1-2L during the day, 3-4L at night. Notify Nurse Practitioner (NP) if change in O2 requirement. Nasal cannula was on the ground when I came to check on her at 11:30 PM, O2 was 91%, will recheck shortly with O2 applied.-On 07/07/2025 at 2:56 PM, Administration note: Apply O2 continuously via nasal cannula to keep O2 saturations 90% or greater; 1-2L during the day, 3-4L at night. Notify NP if change in O2 requirement. Resident's nasal cannula was out of nose.-On 8/18/2025 at 11:26 AM, Nurse note: Resident went to therapy right after breakfast, therapist noted confusion and brought resident to Registered Nurse (RN). RN noted resident's O2 was not turned on. O2sat was 56 %. Turned O2 on at 4L/M [minute] and within 1-2 minutes O2 saturation was 94% at 4L/M. Resident was also more alert and oriented. Resident wished to go back to therapy. When returned O2sat was still 94% with 4L/M.-On 08/18/25 at 9:09 AM, Physician/NP Update: NP updated on resident having O2 turned off while in dining room at breakfast and drop in O2 sat. Family updated as well. Director of Nursing (DON) updated. -On 8/19/2025 at 1:58 PM, Nurse's Note: Writer went in to speak with resident. Resident was having a hard time finding words. Upon assessment, resident was 86% on 3L. Resident stated she was feeling SOB [short of breath]. Instructed resident to take a couple deep breaths, O2 increased to 90%, then resident was breathing normal and O2 dropped to 81%, O2 increased to 4L. Saturation came back up above 90. Resident stated she would like to be evaluated in the ED. Lung sounds diminished throughout. NP updated, family updated and all in agreement to go to Emergency Department (ED). Vital Signs (VS) Blood Pressure (BP) 130/58, Temp 98.5, Respirations (R) 20, Pulse (P) 85, O2 93% on 4L. Emergency Medical Services (EMS) called at 1:37 PM, Report given to ED. EMS came at 1:47 PM.-On 8/19/2025 at 2:43 PM, administration note: Sent to ED.-On 8/19/2025 at 8:47 PM, Nurse's Note: Received call from hospital with update, resident was admitted due to inability to stabilize O2 level and trouble diuresing as well as lower than normal hemoglobin. she will be seen by hospitalist in the morning to determine if she will need a transfusion.-On 9/22/2025 at 1:38 PM, Physician/NP Update: NP updated on resident oxygen being out of her nares after lunch and resident appearing (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unaware. Oxygen at 89% via nasal cannula (NC) @4LPM when writer checked. Increased to 92% when resident not speaking. Care plan and treatment made to ensure nasal cannula is properly in nares throughout shift.Surveyor reviewed a resident/family concern note, dated 07/28/25, which states in part, In nurse report on 07/26/25 it was discussed that Saturday in the morning [R15] was found to have oxygen off for about 30 minutes before turned back on. Coaching was completed to both CNAs assigned to work with [R15] .Surveyor reviewed Employee Coaching form, dated 08/05/25, which states in part, On 07/26/25 [R15] was left without [R15's[oxygen on. [R15's] O2 dropped substantially and put [R15] at risk. Education provided to both CNAs that O2 must always be applied when ordered by a provider. Please ensure you double check all residents with O2 need prior to leaving their room . On 09/22/25 at 1:25 PM, Surveyor observed R15 with nasal cannula for oxygen out of nose and off on right cheek. R15 had requested to have help to room as R15 felt short of breath. Licensed Practical Nurse (LPN) J observed this as well, stopped, placed nasal cannula in nose and educated resident to keep oxygen nasal cannula in nose. LPN J gathered O2 which stated 89% and waited until O2 rose to 92% then contacted primary of the event. On 09/22/2025 at 10:53 AM, Surveyor entered R15's room and observed R15 on toilet in bathroom with call light going off. Surveyor observed CNA H enter R15's room. CNA H then assisted R15 to walker and walked out of bathroom. Surveyor observed CNA H grab R15's wheelchair and began transferring R15 to the wheelchair. Surveyor observed CNA H rearrange oxygen tubing from underneath wheelchair wheels. R15 asked CNA H if there was enough oxygen in the portable tank for R15 before R15 went to a reading activity in the lounge area as R15 had walked with physical therapy earlier this morning and was worried about portable tank being low. CNA H responded to R15 that R15's oxygen tank was fine and that it was filled this morning. Surveyor did not observe CNA H check portable oxygen tank before hooking R15 to the portable tank from R15's concentrator in R15's room. Surveyor observed CNA H grab nasal cannula and place into R15's nose. CNA H went to start pushing R15 out of the room and Surveyor went ahead and asked if CNA H checked portable tank and how much oxygen was left. CNA H reported to Surveyor that CNA H was unsure how much was in portable tank and continued to push R15 out of R15's room to the reading activity in lounge. Surveyor observed CNA H park R15 in wheelchair in the lounge. Surveyor observed CNA H speak to another resident and then left the lounge leaving R15 alone with other resident. On 09/22/2025 at 11:02 AM, Surveyor interviewed Director of Nursing (DON) B and asked if DON B could check R15's portable oxygen tank as Surveyor thought tank was low. DON B walked over to R15 and grabbed portable oxygen tank to check the status of the tank. DON B reported to Surveyor at first that R15's portable tank appeared to be empty, but then DON B stated, Sometimes these tanks are finicky, and you need to grab at this angle of the strap. [R15's] tank appears to be really low and [R15] will need a refill before lunchtime. Surveyor asked DON B what DON B's expectation is of checking portable oxygen tank before R15 is brought out of room to an activity or meals. DON B reported that CNA H should have checked the portable oxygen tank before R15 was brought out. DON B reported that all staff are to check the proper placement of oxygen tubing and how much is in portable tanks before taking out of room off oxygen concentrators. On 09/23/25 at 3:31 PM, Surveyor interviewed DON B and asked DON B's expectations for CNA H to check portable oxygen tanks before R15 was leaving R15's room for activity. DON B reported that all staff should be checking portable oxygen tanks regularly and CNA H should have checked R15's portable tank thoroughly since R15 was concerned. On 09/24/2025 at 12:11 PM, Surveyor interviewed RN K and LPN J and asked once LPN J observed R15 with R15's NC out of nose and on right cheek on 09/22/25, what interventions did LPN J put into place. LPN J reported to Surveyor that LPN J immediately called provider for any new orders, and it was suggested to update care plan. Surveyor asked LPN J and RN K why care plan interventions were not put into place before this event when progress notes show this has happened before. RN K reported to Surveyor that RN K was unaware this had occurred previously. RN K reported to Surveyor that once there is an event like this nursing staff know to update appropriate interventions to decrease the potential of problems. On 09/24/2025 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525680	A. Building B. Wing	09/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
United Pioneer Home	623 S Second St Luck, WI 54853

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at 12:49 PM, Surveyor interviewed DON B and asked why R15 did not have an intervention placed sooner than Monday 09/22/25 with frequent progress notes stating that R15 was found with nasal cannula out of nose. DON B reported that DON B would have to look at R15's record and review the chart as DON B does not know why there wasn't an intervention placed. Surveyor asked if DON B could correlate R15 being found with not being on concentrator with having to send R15 to the ED on 08/19/25. DON B reported to Surveyor that DON B did not correlate it as hospital reported back that R15 was full of fluid and then diuresis in hospital. Surveyor asked DON B why all staff were not educated about proper use of oxygen use. DON B reported to Surveyor that DON B figured this was an isolated event and only educated one staff member. On 09/24/2025 at 12:57 PM, DON B came to Surveyor and handed an employee coaching form to Surveyor stating that on 08/19/25 the staff member was educated on importance of the responsibility to applying oxygen and turning it on the concentrator.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observation, record review and interview, the facility did not ensure that residents are free of significant medication errors for 1 of 12 residents (R12) reviewed for medication errors. R12 has a type 2 diabetes mellitus diagnosis. Facility staff administered short acting insulin 4 hours after Blood Glucose (BG) was taken. Facility staff did not follow standards of practice for insulin administration. Findings include:Surveyor reviewed the policy titled, Insulin Administration, dated reviewed in January 2017, which stated in part, .Insulin Pen: #2. Check blood glucose per physician order or facility protocol.On 09/23/25 at 9:34 AM, Surveyor observed Registered Nurse (RN) I administer Humalog KwikPen 33 units subcutaneous in R12's left abdomen. RN I read out loud to Surveyor that R12's BG (blood glucose) was 173 and completed at 4:12 AM earlier this morning from night shift. RN I reported to Surveyor that R12 will receive sliding scale insulin as well. Surveyor observed RN I give Humalog insulin 33 units and head back to the medication cart. On 09/23/25 at 1:19 PM, Surveyor interviewed RN I and asked what RN I's normal process is for checking BG before giving insulin. RN I reported that sometimes facility has too many BG checks so night shift helps in completing this task for day shift. RN I reported that RN I will use whatever BG night shift obtains to prep for administration of insulins. Surveyor asked RN I if RN I will gather another BG closer to mealtimes for R12. RN I reported that R12 usually fluctuates in the morning and is low so RN I was not concerned with BG taken at 4:12 AM, four hours before insulin was given. On 09/23/25 at 1:22 PM, Surveyor interviewed Director of Nursing (DON) B and asked expectation for checking BG and administering insulins to insulin dependent residents. DON B reported that DON B's expectation for gathering BG should be performed around mealtimes and no earlier than an hour before administering insulins. DON B reported that RN I should have gathered another BG from R12 as using the BG from 4 hours earlier was not acceptable practice.