

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525699	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2025
NAME OF PROVIDER OR SUPPLIER Rennes Health and Rehab Center-Weston		STREET ADDRESS, CITY, STATE, ZIP CODE 4810 Barbican Ave Weston, WI 54476	

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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not implement comprehensive person-centered care plan approaches for 1 of 1 sampled resident (R), (R46) by ensuring fall intervention approaches were in place to meet a resident's medical, nursing, and psychosocial needs which are identified.</p> <p>This is evidenced by:</p> <p>The facility policy, titled Falls and Fall Risk, managing policy statement states, Based on previous evaluations and current data, the staff will identify interventions related to the residents from falling and to try to minimize complications from falling. 6. Staff will identify and implement relevant interventions .to try to minimize serious consequences or falling.</p> <p>R46 was admitted to the facility on [DATE] and has diagnoses of unspecified dementia, mild, with psychotic disturbance with delirium and adult failure to thrive.</p> <p>R46's admission Minimum Data Set (MDS) assessment, dated 01/25/25, indicated a Brief Interview for Mental Status (BIMS) score of 9/15 (mildly impaired) and had a fall in the last month prior to admission and the last 2-6 months prior to admission.</p> <p>R46's fall risk care plan, dated 01/22/25, with a target date of 04/22/25, has interventions approaches dated 01/23/25 of Call don't fall sign placed in room and on 04/14/25 added autolocking brakes to wheelchair.</p> <p>On 05/13/25 at 11:42 AM, Surveyor observed no Call before you fall sign or autolocking brakes on wheelchair for R46.</p> <p>On 05/14/25 at 10:03 AM, Surveyor interviewed Certified Nursing Assistant (CNA) G regarding fall interventions for R46 of signage and brakes. CNA G pulled a CNA care card out of uniform pocket and confirmed that R46 is supposed to have a Call don't fall sign and autolocking brakes on wheelchair to prevent falls.</p> <p>On 05/14/25 at 11:00 AM, Surveyor interviewed Director of Nursing (DON) B regarding fall interventions for R46. DON B stated the sign was found in the resident's drawer and believes R46 does not have usual wheelchair and is investigating on what may have happened.</p>

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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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>Based on observation, interview and record review, the facility did not ensure it was free of medication error rates of 5% or greater. There were 2 errors in 29 opportunities that affected 2 out of 7 residents (R), (R20, R53) included in the medication pass task, which resulted in an error rate of 6.9%.</p> <p>-R5's prescribed topical medication was used for R20.</p> <p>-R53's lidocaine patch was not removed after 12 hours, as ordered.</p> <p>Findings:</p> <p>Example 1</p> <p>The facility's policy, Administering Medications read in part, 3. Medications must be administered in accordance with the orders. The licensed nurse shall follow the five Rights for medication pass: Right Resident, Right Medication, Right Time, Right Dose, Right Route. 5. The individual administering medications must verify the resident's identity before giving the resident his/her medication.</p> <p>On 05/12/25 at 3:50 PM, Surveyor observed Registered Nurse (RN) F completing medication administration for R20. RN F reported she could not administer R20's prescription topical diclofenac sodium gel to both knees, as the medication was not in the medication cart. RN F stated she would update R20's primary care provider (PCP) and the pharmacy to order more. RN F stated she would make a progress note reflecting these actions.</p> <p>On 05/13/25, Surveyor reviewed R20's progress notes, and noted there was not a record indicating RN F updated PCP and pharmacy of R20's medication being unavailable on 05/12/25.</p> <p>Surveyor reviewed R20's medication administration record (MAR) and noted:</p> <p>-05/12/25 PM shift, RN F documented diclofenac sodium gel was not administered due to medication being unavailable.</p> <p>-05/13/25 AM shift, R20's MAR indicated RN C administered R20's diclofenac sodium gel as ordered.</p> <p>On 05/13/25 at 10:20 AM, Surveyor interviewed RN C. RN C stated she did administer R20's diclofenac sodium gel on this date, as ordered. RN C looked in the medication cart for R20's gel, for several minutes. RN C did locate R20's gel and Surveyor noted the tube of diclofenac sodium gel appeared to be new and the dosing card included did not appear to be used. RN C stated she borrowed R5's Voltaren gel (brand name for diclofenac gel) as she was unable to locate R20's diclofenac gel. RN C acknowledged she should not have used R5's medication for R20, as this was not the right resident.</p> <p>On 05/13/25 at 10:32 AM, Surveyor interviewed Director of Nursing (DON) B. DON B reported licensed nursing staff should not use another resident's medication, and she would expect staff to contact the resident's provider for direction. DON B stated she would provide re-education to nursing staff immediately.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Example 2</p> <p>On 05/13/25 at 7:27 AM, Surveyor observed Registered Nurse (RN) C administer medications to R53 which included:</p> <p>Lidocaine 4% Patch (2 patches) on daily to lower back, remove after 12 hours</p> <p>On 5/13/25 at 7:29 AM, Surveyor observed RN C remove one patch from R53's lower back which was left on from previous day and not removed per physician orders. RN C removed glove, performed hand hygiene, put on a new glove, and applied two new patches to R53's lower back.</p> <p>Surveyor reviewed R53's medication administration record (MAR) for Lidocaine patch order which reads:</p> <p>Lidocaine adhesive patch, medicated; 4%; amount: 2 patches; topical</p> <p>Apply daily, remove 12 hours after applying ON AM, OFF HS</p> <p>Surveyor reviewed R53's MAR, which indicated the patches from the previous day had been removed by Licensed Practical Nurse (LPN) Q, who was not available for interview.</p> <p>On 05/14/25 at 12:31 PM, Surveyor interviewed LPN R. LPN R stated if orders indicate lidocaine patches are to be placed one time daily and removed after 12 hours, the MAR would prompt the nurse to remove patch on PM shift. LPN R stated patches are on for 12 hours and off for 12 hours.</p> <p>The facility did not ensure physician order for Lidocaine patch was followed as ordered.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, interview and record review, the facility did not ensure proper food handling practices related to thawing raw meat were followed to prevent the outbreak of foodborne illness for 26 of 82 residents.</p> <p>Facility did not use proper thawing method for frozen pork chops.</p> <p>Policy and procedure titled Food Preparation and Service last revised in August of 2014 reads in part, Submerging the item in cold running water.</p> <p>Guidelines from Agriculture, Trade, and Consumer Protection Subpart 3-501.13 last registered in November 2024, reads in part, Completely submerged under running water .With sufficient water velocity to agitate and float off loose particles in an overflow.</p> <p>The FDA Food Code states the following:</p> <p>3-501.13 Thawing. Except as specified in (D) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be thawed:</p> <p>(B) Completely submerged under running water:</p> <p>(1) At a water temperature of 21oC (70oF) or below,</p> <p>(2) With sufficient water velocity to agitate and float off loose particles in an overflow, and</p> <p>(4) For a period of time that does not allow thawed portions of a raw animal FOOD requiring cooking as specified under 3-401.11(A) or (B) to be above 5oC (41oF), for more than 4 hours including:</p> <p>(a) The time the FOOD is exposed to the running water and the time needed for preparation for cooking.</p> <p>On 05/14/25 at 8:23 AM, Surveyor observed pork chops, which appeared to be thawed, in a pan of water placed in the small sink of the prep table. Pork tenderloins were partially red/partially browning in color. Surveyor observed the pork chops sitting in still water, not running water.</p> <p>On 05/14/25 at 8:49 AM, Surveyor observed pork chops in the same water. This was not cold running water. Surveyor interviewed Dietary Manager (DM) S and [NAME] T. DM S stated the pork chops were thawing and had been taken out of the freezer that morning. [NAME] T stated [NAME] T had taken the pork chops out of the freezer when [NAME] T got to work that morning.</p> <p>On 05/15/25 at 7:50 AM, Surveyor interviewed DM S. DM S stated that [NAME] T may have run the pork tenderloins underwater prior to Sureyor's observation but wasn't positive. DM S stated [NAME] T would most likely have rinsed the pork chops before cooking them. [NAME] T reported the pork chops were partially frozen in the middle when he took them out of the still water. The pork chops were then breaded and cooked and served to 26 residents. Cooked internal temp was recorded at 193 degrees.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 05/15/25 at 9:34 AM, Surveyor interviewed Director of Corporate Food Services (DCFS) U. DCFS U stated DCDS U was informed by [NAME] T the water had been running until about 8:00 AM that morning and it was shut off due to [NAME] T leaving the kitchen. At that time the pork was left in the sitting water.</p> <p>Surveyor determined the facility did not follow safe and appropriate thawing methods for frozen pork, which had the potential for contributing to foodborne illness.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not maintain infection control practices to help prevent the development and transmission of communicable diseases and infection for 1 of 1 resident (R) reviewed (R57).</p> <p>- R57's Foley catheter collection bag was observed placed above bladder level allowing backflow which can contribute to infections. On 05/13/25, half of R57's Foley catheter bag was lying on the floor uncovered.</p> <p>This is evidenced by:</p> <p>The facility policy titled, Catheter Care, Urinary indicates the following, . 4. The urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder . 11. Be sure the catheter tubing and drainage bag are kept off the floor.</p> <p>R57 was admitted to the facility on [DATE] with diagnoses including surgical aftercare following surgery on the urinary system, urogenital implants, urinary tract infection, lobulated, fused and horseshoe kidney, sepsis, kidney stones, enlarged prostate with lower urinary tract symptoms, obstructive and reflux uropathy, and feeling of incomplete bladder emptying.</p> <p>R57's care plan, dated 4/2/25, includes the following:</p> <p>Problem: Resident requires an indwelling urinary catheter R/T obstructive and reflux uropathy</p> <p>Approach: Keep catheter system a closed system as much as possible, Position bag below level or the bladder and use a catheter strap.</p> <p>On 05/12/25 at 1:25 PM, Surveyor observed R57 being brought to the dining room by spouse with R57's catheter bag placed on lap above bladder level during lunch. Surveyor asked Licensed Practical Nurse (LPN) E if they see anything concerning with R57. LPN E stated that R57's catheter bag is on his lap and explained R57 just returned from an appointment with the urologist, and no one must have seen it yet. LPN E added LPN E will take care of the catheter right away. Surveyor reviewed the nursing progress note dated 05/12/25 at 12:41 PM, (which was 1 hour and 16 minutes before the observation) stating R57 returned to the facility from his appointment. The note was entered by LPN E.</p> <p>On 05/13/25 at 7:38 AM, Surveyor observed R57's Foley catheter drainage bag clipped to bottom of the wheelchair with 1/2 of the bag uncovered and resting on the floor. Surveyor interviewed Certified Nursing Assistant (CNA) L and asked who provided morning care for R57. CNA L said CNA L and CNA M provided care for R57. Surveyor asked CNA L if CNA L noticed anything wrong with R57's catheter bag. CNA L said, Oh yes. It is supposed to be in the bag on the back of the wheelchair. CNA L immediately sanitized hands, donned gown and gloves, and placed the catheter bag in the privacy bag on the back of R57's wheelchair.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/13/25 at 2:49 PM, Surveyor interviewed Infection Preventionist (IP) O and asked what the expectation would be for staff regarding managing Foley catheters. IP O vocalized staff should place the Foley catheter bags below the bladder level to prevent backflow and infection. The catheter bag is to be in privacy bag off the floor, and place resident on Enhanced Barrier Precautions (EBP). Surveyor discussed the observations, and IP O stated she will start providing education right away.</p> <p>On 05/15/25 at 8:20 AM, Surveyor interviewed DON B who said DON B was made aware of the catheter concerns and the facility has already begun educating staff</p>