STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	52A429	A. Building B. Wing	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sky View Nursing Center	309 Iron St Hurley, WI 54534

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 interview and record review, the facility did not ensure 3 of 3 residents (R3, R18, and R21) or the residents' legal representatives were notified of the reason for a transfer/discharge and did not ensure they were provided a bed hold policy in writing including the rate to reserve the residents' beds.The facility did not include the daily rate for bed hold to R18 and R21 prior to transfer to hospital.R3's, R18, and R21 transfer form did not contain appeal rights or ombudsman contact information. Findings include: Example 1 R18 was admitted to the facility on [DATE]. On 03/17/2026 and 04/04/2026, R18 was transferred to the hospital. R18's medical record did not include documentation that R18 or R18's legal representative was provided with written or verbal communication of bed-hold daily rate charges. The facility's written transfer/discharge notice did not include ombudsman contact or the resident's right to appeal discharge for R18. Example 2 R21 was admitted to the facility on [DATE] On 01/01/2026 and 02/11/2026, R21 was transferred to the hospital. R21's medical record did not include documentation that R21 or R21's legal representative was provided with written or verbal communication of bed-hold daily rate charges. On 04/29/2026 at 8:30 AM, Surveyor interviewed Nursing Home Administrator (NHA) A if R18 and R21 were provided bed-hold daily rates. NHA A could not provide this information for R18 and R21. The facility's written transfer/discharge notice did not include ombudsman contact or the resident's right to appeal discharge for R21. Example 3 R3 was admitted to the facility on [DATE]. On 11/20/25, R3 was transferred to the hospital. R3's notice of transfer notice did not include appeal rights or Ombudsman contact information.

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 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 interviews and record reviews, the facility did not ensure that residents received treatment and care in accordance with professional standards of practice to maintain a resident's highest practicable level of physical well-being for 1 (R25) of 12 residents reviewed.R25 was diabetic and had as-needed (PRN) insulin for blood sugars > (greater than) 400 mg (milligrams)/dL (deciliter). The facility did not follow the provider's orders to administer PRN (as needed) insulin and did not notify the provider of blood sugars outside of parameters.This is evidenced by:R25 was admitted to the facility on [DATE] with a diagnosis of type 2 diabetes mellitus with hyperglycemia.R25's physician orders include:On 05/09/25, Facility standing orders ok.On 03/05/26, Novolin R (regular insulin) give 10 units subcutaneously for blood sugars >/= (equal to) 400 as needed every 2 hours until blood sugar < (less than) 300.Surveyor reviewed R25's medication administration record (MAR):On 03/21/2026 at 6:09 PM, blood sugar documented as 413 mg/dL; 10 units of Novolin administered; at 9:28 PM, follow-up blood sugar was 323 mg/dL. Of note: No additional Novolin was administered to reduce R25's blood sugar to less than 300 as ordered. There is no documentation that the provider was notified of R25's blood sugar of 413 mg/dL. On 03/22/2026 at 4:59 PM, blood sugar documented as 416 mg/dL; 10 units of Novolin administered; at 8:54 PM, follow-up blood sugar was 349 mg/dL. Of note: No additional Novolin was administered to reduce R25's blood sugar to less than 300 mg/dL as ordered. There is no documentation that the provider was notified of R25's blood sugar of 416 mg/dL. On 04/03/2026 at 4:21 PM, blood sugar documented as 446 mg/dL; 10 units of Novolin administered. Of note: No follow-up blood sugar documented. There is no documentation that the provider was notified of R25's blood sugar of 446 mg/dL. On 04/19/2026 at 3:52 PM, blood sugar documented as 415 mg/dL; 10 units of Novolin administered. Of note: No follow-up blood sugar documented. There is no documentation that the provider was notified of R25's blood sugar of 415 mg/dL. On 04/21/2026 at 3:21 PM, blood sugar documented as 436 mg/dL; 10 units of Novolin administered; at 6:33 PM, follow-up blood sugar was 400 mg/dL. Of note: No additional Novolin was administered to reduce R25's blood sugar to less than 300 as ordered. There is no documentation that the provider was notified of R25's blood sugar of 436 mg/dL. On 04/28/26 at 10:27 AM, Surveyor interviewed Licensed Practical Nurse (LPN) C regarding blood sugars. LPN C stated that she believed the facility's standing orders were to notify the provider if a resident's blood sugar is <60 and >400 but wasn't sure. Surveyor asked LPN C if this gets documented anywhere. LPN C stated that a communication form is filled out, faxed to the provider and put in the resident's paper chart and a progress note is entered into the MAR (medication administration record). Surveyor asked LPN C about R25's Novolin insulin order. LPN C stated that if additional doses of Novolin had to be given it would be entered in the MAR and in a progress note.On 04/28/26 at 11:33 AM, Surveyor interviewed Director of Nursing (DON) B regarding R25's insulin orders and blood sugars. DON B stated that the facility's standing orders are for the nurse to notify the provider if blood sugars are >400 and to document the communication in a progress note, unless the provider enters a specific parameter for notification. Surveyor asked DON B to review R25's Novolin order and MAR entries for the month of April 2026. DON B was unaware the provider's order was not being followed and stated the nurse should have administered additional Novolin and notified the provider of the >400 blood sugar.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 to help prevent the development and transmission of communicable disease and infections for 2 (R9, R7) out of 13 residents observed. The facility did not have Enhanced Barrier Precaution (EBP) signage displayed near the door or in room for a resident on Enhanced Barrier Precautions (EBP) and staff did not consistently use Personal Protective Equipment (PPE) when in direct contact with R7 who is on EBP.Staff inserted eye drops for R9 with contaminated gloves and did not practice hand hygiene when gloves were changed.Findings include:Example 1On 4/27/2026 at approximately 10 AM, Surveyor observed R7 has a urinary catheter. R7 does not have Enhanced Barrier Precaution (EBP) signage near the entry of his room or anywhere in his room. Surveyor also observed there was no Personal Protective Equipment (PPE) in the entry way or room of R7.On 4/28/2026 at 1:04 PM, Surveyor observed Certified Nurse Assistant (CNA) D wheel R7 into the shared bathroom and empty R7's catheter after putting on a gown, face shield, and gloves. Surveyor interviewed CNA D, who stated staff only needed to wear the PPE when providing catheter care for R7. On 4/28/2026 at 1:25 PM, Surveyor interviewed CNA D and Director of Nursing (DON) B. Both stated a gown only needs to be worn when providing catheter care or coming in contact with the catheter. DON B showed Surveyor that R7 has a drawer near his bed with PPE and inside the drawer contained an EBP sign. Surveyor asked DON B how staff know R7 is on EBP and when to wear PPE. DON B reported staff are told who is on EBP. On 4/28/2026 at 1:50 PM, Surveyor interviewed CNA E, who reported she has cared for R7 before. CNA E stated R7 is on droplet precautions, just for his catheter though. CNA E reported she would wear a gown and gloves only when working with R7's catheter in case urine was splashed. On 4/29/2026 at 8:30 AM, Surveyor interviewed Nursing Home Administrator (NHA) A and DON B, who agreed that EBP was not understood by staff. NHA A and DON B indicate staff did not understand the need to wear PPE when providing any direct care to R7 who has a catheter and is on EBP.Example 2On 4/28/2026 at 10:45 AM, Surveyor observed Licensed Practical Nurse (LPN) C apply gloves then pick up R9's used drinking cup by the rim and throw it away. LPN C then proceeded to administer R9's eye drops with contaminated gloves. Surveyor observed LPN C remove her contaminated gloves and apply clean gloves without practicing any hand hygiene. On 4/28/2026 at 10:50 AM, Surveyor interviewed LPN C who agreed she should not have touched the rim of R9's used cup and then with the same contaminated gloves to apply R9's eyedrops. LPN C also agreed she should have sanitized her hands when she changed her gloves.