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	06/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Minocqua Health and Rehab	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 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to receive visitors of his or her choosing, at the time of his or her choosing. 41945 Based on interview and record review, the facility did not ensure the resident's right to receive visitors of his or her choosing at the time of his or her choosing, and in a manner that does not impose on the rights of another resident. This practice had the potential to affect 39 of 39 residents. *The facility stopped visitation within the facility on 05/08/22 due to a COVID 19 outbreak within facility and did not allow private and uninterrupted visits according to current standards of practice and visit recommendations outlined in the Centers for Medicare and Medicaid Services (CMS) QSO-39-NH memo, Nursing Home Visitation - COVID, revised on 03/10/22. Facility did not provide visitors or residents information on the risks and benefits of visitation during an outbreak and allow them to make the choice whether or not to visit. The facility did not have a process in place to provide notification to residents or family members when visiting was interrupted due to an outbreak. Findings include: The CMS QSO-2-39 memo (dated 09/17/20 and revised 03/10/22) states, in part: .If a visitor, resident, or their representative is aware of the risks associated with visitation, and the visit occurs in a manner that does not place other residents at risk (e.g., in the resident's room), the resident must be allowed to receive visitors as he/she chooses . The CMS QSO-2-39 memo (dated 09/17/20 and revised 03/10/22) states, in part: .Facilities must allow indoor visitation at all times and for all residents as permitted under the regulations. While previously acceptable during the PHE, facilities can no longer limit the frequency and length of visits for residents, the number of visitors, or require advance scheduling of visits . The CMS QSO-2-39 memo (dated 09/17/20 and revised 03/10/22) states, in part: .While it is safer for visitors not to enter the facility during an outbreak investigation, visitors must still be allowed in the facility. Visitors should be made aware of the potential risk of visiting during an outbreak investigation and adhere to the core principles of infection prevention. If residents or their representative would like to have a visit during an outbreak investigation, they should wear face coverings or masks during visits, regardless of vaccination status, and visits should ideally occur in the resident's room. Facilities may contact their local health authorities for guidance or direction on how to structure their visitation to reduce the risk of COVID-19 transmission during an outbreak investigation . (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's visitation policy, which is not dated, states, in part: .It is the policy of this facility to promote the resident's right to access visitors of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident . The facility's visitation policy states, in part: .Immediate family, relatives, and other visitors of resident's choosing are not subject to visiting hour limitations or other restrictions. Non-family visitors must also be granted immediate access to the resident . The facility's visitation policy states, in part: .Covid-19 Visitation-Visitors will be asked to not visit if they have signs or symptoms of a respiratory infection, such as a fever, cough, and sore throat; has had contact with someone with or under investigation for COVID-19. Upon entry all visitors will be required to sign in, take temperature and respond to the COVID-19 prescreening questions . Surveyor reviewed the facility's visitor log for May 2022. No visitors were on record for May 8, 2022. On 05/31/21 at 12:48 p.m., Surveyor interviewed R2's family member (FM) I. FM I stated family tried to visit R2 but was not allowed to visit on Mother's Day (05/08/22). FM I stated they were told there was no visitation due to 4 residents having COVID-19. FM I stated she called the facility and was told visitation was stopped until 05/29/22. FM I could not recall who she spoke with at the facility. On 06/01/22 at 1:26 p.m., Surveyor interviewed PH (public health) H. Surveyor asked PH H if facility had contacted Public Health regarding COVID positive residents. PH H stated DON B called on 05/07/22 and stated 5 residents in the facility tested positive for COVID and wanted guidance as to what to do regarding visitation. PH H stated she told DON B that the recommendation would be to stop visitation for 5 days, residents should wear masks, and social distance. DON B stated the residents would not wear masks, would not socially distance, and were also asymptomatic. PH H stated recommendation would be to stop visitation for 10 days due to no masks, no social distancing, and asymptomatic status. PH H stated she had told DON B that this was only a recommendation, not a public health order, and that it was at the discretion of the facility to stop visitation if they chose to do so. PH H stated DON B contacted public health on 05/09/22 and stated the facility had 5 more COVID positive residents. PH H stated she told DON B the same recommendations that were made on 05/07/22, and that the decision to stop visitation was up to the facility as it was not a public health order, only a recommendation. On 05/18/22, PH H stated DON B contacted public health to inform them that there was one additional resident who tested positive for COVID-19. PH H stated DON B wanted to know if facility should remain closed through 05/28/22. PH H stated she told DON B the recommendation would be to stop visitation for 10 days due to no masks worn, and no social distancing. PH H stated she told DON B the decision was ultimately the facility's decision since this was a recommendation, and not a public health order. On 06/01/22 at 2:17 p.m., Surveyor interviewed Hospice Coordinator (HC) E asking about visitation for performing an admission. On 5/13/22 hospice nurse was to come see R1 to assess if he would qualify for services. Social Worker (SW) J informed hospice that R1 has had increased behaviors and the facility had COVID in the building and would like to wait for R1 to be assessed as not able to enter the facility. (continued on next page)

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F 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 06/01/22 at 3:24 p.m., Surveyor interviewed DON B. Surveyor asked DON B about visitation being stopped and asked if facility had contacted public health. DON B stated she had contacted public health and stated she spoke with PH H. Surveyor asked what date that was. DON B could not recall the specific date. DON B stated public health told her to stop visitation. Surveyor asked what date visitation was stopped. DON B stated visitation was stopped on 05/11/22. Surveyor asked about the two residents, (R7 and R8), whose medical records have documentation of testing positive for COVID on 05/07/22. DON B stated R7 and R8 tested positive on 05/11/22. Surveyor asked DON B when visitation was resumed. DON B stated it would have been resumed 10 days after 05/11/22, but more residents tested positive on 05/18/22, so it was extended until 05/28/22 and visitation would resume 05/29/22. DON B stated visitation was resumed on 05/26/22 because she had received a call from the Ombudsman and was told the facility could not stop visitation per CMS guidelines. Surveyor asked about 05/08/22 (Mother's Day) and no visitation. DON B stated there should have been visitation because visitation wasn't stopped until 05/11/22 when residents tested positive for COVID. Surveyor stated a family was told by the facility that they could not visit on 05/08/22 and that visitation would not be resumed until 05/29/22. DON B stated she did not who would have told a family that. Surveyor asked if DON B was aware of the CMS QSO-2-39 memo, and she reported she was not. The facility failed to allow private and uninterrupted visits according to current standards of practice and visit recommendations outlined in the Centers for Medicare and Medicaid Services (CMS) QSO-39-NH memo Nursing Home Visitation-COVID-revised on 03/10/22.

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F 0689 Level of Harm - 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** 31086 Based on interview and record review, the facility did not ensure the resident's environment remains as free of accident hazards as possible and each resident receives adequate supervision and assistive devices to prevent accidents. This occurred for 3 of 3 residents who were reviewed for falls, Residents (R) R1, R5, and R6. R1 sustained a fall and facility staff did not provide supervision and R1 immediately fell again resulting in facial fractures. The facility did not provide immediate supervision, investigate to identify a root cause, implement new interventions, or evaluate the effectiveness or modify interventions. After R5 and R6 fell , the facility did not investigate to identify a root cause, implement new interventions, or evaluate the effectiveness or modify interventions. This is evidenced by: Review of facility's policy titled, Falls and Fall Risk, Managing, with the revised date of March 2018, read in part: .Resident-Centered Approaches to Managing Falls and Fall Risk .5. If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. 6. If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category of falling, until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable .Monitoring Subsequent Falls and Fall Risk .1. The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling .3. If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions . Review of R1's medical record documents current diagnoses of traumatic subarachnoid hemorrhage without loss of consciousness, dementia with behavioral disturbance, repeated falls, anxiety disorder, insomnia, chronic kidney disease stage 2, and dysphagia. Review of the Minimum Data Set (MDS) dated [DATE], a quarterly assessment, documented R1 as having severely impaired cognitive skills for daily decision making. The MDS documents R1 as having two or more falls without injury and one fall with injury that was not a major injury. Review of fall risk assessments completed on 05/21/22 and 05/04/22 documented R1 having a score of 18, identifying as being at high risk for falling. Review of comprehensive care plans identified on 05/27/22, the fall care plan focus had added, Resident has chair alarm on w/c, kept at nurse's station for observation to avoid falls. No new fall interventions were added. The last revision to the high risk for falls care plan was completed on 03/19/22. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of progress notes documented, in part: 05/21/22 7:16 p.m., Writer heard CNA [certified nursing assistant]yell for the nurse, Resident stood up by the nurses station and fell over. Resident did not hit head but does have a cut on right index finger. Left resident to call POA to notify about fall. Resident then stood up and fell face first into the floor by the nurses station. POA was on the phone when this happened was notified. Resident was bleeding from nose and started swelling in his face. EMS was notified immediately and was sent out to . Hospital . 05/21/22 7:18 p.m., 'Injuries to resident post fall are bruise to bottom left lip, right black eye, swelling to nose and face. Resident passed a quarter size clot from his right nostril but was continuing to have epistaxis. Has a laceration to right index and ring finger. Resident is alert and oriented x1. Resident first fall was at 1615 (4:15 p.m.) and second fall was at 1620 (4:20 p.m.) while writer was on the phone with POA (Power of Attorney). Both falls happened next to nurses station. Resident's mouth was intact and dentures not broken. Resident did call out with pain but writer help (sic) a towel with ice pack to resident's face. Police officer . arrived on scene to assist until medics arrived. Medics (Names) transported resident to (Name) Hospital . DON (Director of Nursing) was notified of incident. 05/21/22 7:23 p.m., .RN from ER called resident has a periorbital fracture and maxilla fracture. They are awaiting for surgical consults and will notify when resident is to return. 05/21/22 8:59 p.m., Resident returned from (Name) ER via son and was helped into facility by staff at 2030 (8:30 p.m.) Resident diagnosed with [NAME] II fracture, frontal sinus fracture, facial swelling and UTI. Macrobid PO 100mg capsule BID for 10 days ordered. Resident is to have puree diet and to leave dentures out for 5 days. 05/22/22 7:16 a.m., Resident has lots of swelling and bruising to face. Resident is unable to (sic) medications this morning due to swelling of face and mouth. Applied ice pack to face and checked oxygen saturation which was 94 on room air. Resident has a gurgle noise when breathing and nose is still bleeding. Will continue to monitor. Will update MD. 05/22/22 9:54 a.m., Talked with POA about seeing if he would be ok with getting resident evaluated for hospice. POA confirmed he was ok with his father being evaluated for hospice due to recent events. Upon review of R1's medical record, Surveyor did not find a fall investigation report determining the root cause, identification of hazards and risks and implementation of interventions or supervision to prevent future falls. The medical record did not document reviews of the effectiveness of interventions or modifications of interventions. The medical record did not document neurological assessments upon return to the facility and only had a neurological assessment documented once daily as being within normal limits. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 05/31/22 at 11:19 a.m., Surveyor interviewed Registered Nurse (RN) D about R1's fall interventions. RN D indicated a Hospitality Aide was just hired and will sit with R1 and assist staff passing water and meal trays. RN D indicated the Hospitality Aide just started this past weekend. RN D indicated R1 is not able to tell if he is having pain and has had no signs or symptoms of pain over the weekend. RN D reviewed what interventions are in place to prevent falls and indicated there were no new interventions since the last fall. They have a put together a book about meters as this was R1's previous job of reading meters. On 05/31/22 at 1:29 p.m., DON B indicated not having a completed fall investigation for R1. Surveyor requested R1's ER notes and orders. DON B indicated not being able to locate the documents and that it would take days to receive from the hospital. On 05/31/22 at 2:10 p.m., Surveyor interviewed Licensed Practical Nurse (LPN) C asking about R1's fall. LPN C indicated R1 fell and had no injuries noted and no reports of pain. R1 was sitting by the nurse's station and LPN C went to chart and call POA. When on the phone with POA, LPN C heard a thud and the chair alarm sounding and found R1 on the floor bleeding from his face. Called 911 and sent R1 to the hospital. A nurse from the ER called and stated R1 had multiple fractures to face. LPN C indicated when a resident has a fall with head injuries, neurological checks are to be done and would be in the 24-hour binder. 05/31/22 at 4:00 p.m., Surveyor reviewed with Nursing Home Administrator (NHA) A the concerns of R1's fall and that no immediate supervision was provided to prevent further falls. Within minutes, R1 then fell again causing major injuries of fractures to R1's face. The facility did not complete an investigation to determine the root cause of the fall, and did not put any interventions into place to prevent further falls. Reviewed with NHA A R5 and R6 also having falls and no investigations were completed. On 06/01/22 at 7:15 a.m., Surveyor interviewed DON B about the fall investigations. DON B indicated the staff should be filling out the fall investigation paper report and this has not been completed. DON B indicated not being able to catch up on job duties since having to work the night shift as the floor nurse. DON B indicated there has been no interdisciplinary team since being in between Nursing Home Administrators. DON B stated, Things have fell by the wayside. On 06/01/22 at 10:14 a.m., Surveyor interviewed MD G asking about R1's fall, pain, and hospice. MD G indicated R1 has a history of falls related to dementia. R1 is always in the wheelchair and trying to get out of chair and R1 needs distraction to prevent from getting up. R1 is very impulsive and very high fall risk. Example 2: Review of R5's medical record documents current diagnoses of Alzheimer's, dementia, hemiplegia, and depression. Review of fall risk assessments dated 05/24/22 having a score of 15, 04/21/22 having a score of 11, and on 04/08/22 a score of 14. The fall risk assessment score of 10 or greater identifies as being at high risk for falls. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the progress notes document on 05/26/22, R5 had a fall to the floor and was found between the bed and wheelchair. Review of R5's medical record; Surveyor did not find a fall investigation report determining the root cause, identification of hazards and risks and implementation of interventions or supervision to prevent future falls. The medical record did not document reviews of the effectiveness of interventions or modifications of interventions. Review of the care plan did not document new fall interventions. On 05/31/22 at 1:29 p.m., DON B indicated not having a completed fall investigation for R5. Example 3: Review of R6's medical record; documents current diagnoses of dementia without behavioral disturbance, dysphagia, cognitive communication deficit, and depression disorder. Review of the progress notes document on 05/15/22; R6 had a fall to the floor, found sitting next to bed. R6 states had slid out of bed because didn't have bar to grab onto. Review of R6's medical record; Surveyor did not find a fall investigation report determining the root cause, identification of hazards and risks and implementation of interventions or supervision to prevent future falls. The medical record did not document reviews of the effectiveness of interventions or modifications of interventions. Review of the care plan did not document new fall interventions. On 05/31/22 at 1:29 p.m., DON B indicated not having a completed fall investigation for R6.

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41945 Based on record review and interview, the facility did not ensure 1 out of 3 sampled residents (R2) was free of significant medication errors. *R2 was taking Levothyroxine for underactive thyroid due to hypothyroidism. R2's Nurse Practitioner (NP) ordered a medication increase from 75mcg by mouth daily to 125mcg by mouth daily on 04/28/22 due to an elevated TSH level of 111.18. Normal TSH levels are 0.25-5.0. R2 did not receive Levothyroxine dose increase from 04/29/22 through 05/18/22 when R2 was hospitalized for unresponsiveness and diagnosed with myxedema coma. Increased dose of Levothyroxine was not received for 20 days before R2 was hospitalized . *Upon readmission to facility from hospital on 05/26/22, R2 did not receive Levothyroxine 125mcg by mouth daily ordered on discharge from hospital from 05/27/22 through 06/01/22 when omission identified. R2 did not receive the Levothyroxine for 6 days until error identified upon readmission. Findings include: R2's original admitted to the facility was on 08/31/18. R2's diagnoses include, in part: .Hypothyroidism, Unspecified dementia without behavioral disturbance, Moderate protein-calorie malnutrition, Major depressive disorder, Atherosclerotic heart disease of native coronary artery without angina pectoris, Adult failure to thrive, Type 2 Diabetes Mellitus without complications, Hyperlipidemia, Essential (primary) hypertension . Surveyor reviewed R2's Levothyroxine dose from 12/01/21 through 06/01/22. R2's physician order for Levothyroxine from 12/01/21 through 04/28/22 was 75mcg by mouth daily. On 04/28/22 the order was changed to 125mcg by mouth daily. The facility never transcribed this order into R2's medical record. R2 continued to receive 75mcg by mouth daily until 05/18/22. On 05/18/22, R2 was hospitalized . On 05/26/22 R2 was discharged from the hospital and returned to facility with a physician order (signed prescription) for Levothyroxine 125mcg by mouth daily. The order from the hospital on discharge was never transcribed into R2's medical record. R2 did not receive Levothyroxine dose of 125mcg by mouth from 05/27/22 through 06/01/22 when error identified. Surveyor reviewed R2's MAR (Medication Administration Record) from 12/01/21 through 06/01/22. Monthly MARs documentation shows all Levothyroxine 75 mcg were administered correctly 12/1/21 - 3/31/2022. April 2022: Levothyroxine 75mcg tablet orally in the morning. All doses from 04/01/22 through 04/30/22 documented as given. No order change documented for 04/28/22 changing the dose to 125mcg tablet orally in the morning as per physician order, so R2 received 75mcg daily and not 125mcg from 04/29/22 through 04/30/22. May 2022: Levothyroxine 75mcg tablet orally in the morning (MAR does not have dose transcribed as 125mcg tablet as per order 04/28/22). R2 received 75mcg tablet orally 05/01/22 through 05/04/22. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Levothyroxine dose of 75mcg received except on 05/04/22 through 05/06/22 MAR is marked as R2 in hospital. On 05/07/22 through 05/12/22 Levothyroxine 75 mcg documented as given (not 125 mcg that was ordered). On 05/13/22 no documentation for dose. On 05/14/22 through 05/18/22 Levothyroxine 75 mcg documented as given. On 05/19/22 through 05/22/22 R2 documentation stated R2 in hospital. On 05/23/22 through 05/27/22 documentation for Levothyroxine is blank. On 05/28/22, 05/29/22, 5/31/22 Levothyroxine documented as refused. On 05/30/22 dose documented as given. Surveyor spoke with LPN (Licensed Practical Nurse) C on 06/01/22 at 9:30 a,m., and asked to see Levothyroxine medication and LPN C stated R2 was not on Levothyroxine medication and there was no medication card. June 2022: MAR documents dose of Levothyroxine as 75mcg tablet orally (which is incorrect dose) in the morning and documented as given on 06/01/22, which doesn't coincide with interview with LPN C and LPN C could not produce proof of Levothyroxine medication. R2's medical record reviewed for TSH levels and physician/NP documentation from 12/01/21 to 06/01/22. -Physician order dated 12/17/20 stated TSH in one year. No documentation of TSH for 12/2021. No documentation in R2's medical record for labs drawn nor results for TSH levels. Surveyor received documentation for labs for TSH level and physician and NP documentation. -Physician nursing home visit on 02/17/22 stated R2 was due for a TSH level. -R2 had clinic visit on 04/26/22. Documentation per clinic stated on 04/28/22 clinic RN spoke to DON B at the facility and DON B stated she had not seen a recent TSH level. Clinic informed DON B of lab result of 111.18 and need to increase medication and repeat lab in 10 weeks. Documentation stated order sent to facility as well. (Normal TSH is 0.4 to 4; levels above 4-5 indicate an underactive thyroid.) Surveyor reviewed fax cover sheet and documentation sent to facility from clinic. Fax cover sheet dated 04/29/22 at 12:16 p.m. Documentation included: Order from NP for 1. Levothyroxine 125 mcg p.o. (by mouth) daily and 2. Repeat Thyroid (TSH) lab in 10 weeks. Order signed by NP. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Surveyor reviewed R2's medical record for hospital discharge information from hospitalization from [DATE] through 05/26/22. Discharge summary by NP from the medical facility stated when R2 was sent to the emergency department for evaluation, R2's blood pressure was 72/40. Documentation stated initially R2 was not able to respond to questions or any verbal commands nor would she make her needs known. Incidental findings also included COVID but asymptomatic. Subsequently, due to her hypothyroidism R2's TSH level was checked and came back at 190. Diagnosis included myxedema coma. Levothyroxine was increased from 75mcg daily to 125mcg daily. Documentation states R2 clinically did not show signs of improvement and after 4 days a second TSH was checked and came back at 120. Documentation stated clinically R2 improved to baseline, which included simple responses to questions, but not able to use the call light nor make needs known. While at the hospital, a palliative care meeting was held with R2's daughter, who is also R2's Power of Attorney (POA). It was decided that R2 be admitted to hospice and return to the nursing home facility. Included with the hospital discharge summary were copies of signed prescriptions, which included Levothyroxine 125mcg Tablet by mouth once daily. This order was never transcribed into R2's MAR at the facility upon readmission on 05/26/22. Included with the hospital discharge summary was a discharge patient sheet, which listed R2's medication on it. Levothyroxine 125mcg 1 tablet by mouth daily was listed and it was documented to start taking on 05/27/22. The medication list was electronically signed by the NP from the medical facility. On 05/31/22 at 12:05 p.m., and 06/02/22 at 09:30 a.m., Surveyor attempted to contact NP L who had prescribed the Levothyroxine 125 mcg from the admitting medical facility. No return call received from NP L. On 05/31/22 at 11:25 p.m., Surveyor interviewed Social Worker (SW) F. Surveyor asked SW F about Levothyroxine medication and orders per clinic. SW F stated R2 had an appointment at the clinic on 04/26/22 and R2's TSH level was high at 111.18. SW F stated the clinic sent a fax on 04/28/22 with an order to increase the thyroid medication to 125mcg daily and to repeat the TSH in 10 weeks. SW F stated the facility did not increase the medication and R2 wound up in the hospital. 05/31/22 at 1:00 p.m., Surveyor interviewed DON B. Surveyor asked why Levothyroxine was not changed from 75mcg by mouth daily to 125mcg by mouth daily, when NP changed the order on 04/28/22. DON B stated the facility never received the fax from the clinic. Surveyor asked DON B why no follow-up on the TSH level since DON B wrote in the nursing progress notes on 04/26/22 that R2 went to clinic and part of labs drawn were a TSH level. DON B stated there is not enough staff and she is only one person to do it all. Surveyor asked why the discharge orders, which included a signed script for Levothyroxine 125mcg by mouth daily, were not transcribed into R2's MAR when the order for Morphine Sulfate and Lorazepam were transcribed and entered into the medical record. DON B unaware of omission.

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	525678	A. Building B. Wing	06/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Minocqua Health and Rehab	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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 41945 Based on record review and interview, the facility did not establish an Infection Prevention and Control Program (IPCP) to include outcome surveillance systems to prevent the spread of communicable diseases, such as COVID-19. This has the potential to affect all 39 residents. There is no evidence of daily or outcome surveillance such as a system to analyze infections, identify trends, patterns, and rates of infections to help prevent the transmission of infections. Findings include: According to the Center for Medicare and Medicaid Services (CMS) 42 CFR 483 Requirements for Long Term Care Facilities: The facility must 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. (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to S483.70(e) and following accepted national standards; (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility. On 05/31/22, Surveyor reviewed facility's infection prevention and infection control surveillance. The facility produced no evidence of a daily or outcome surveillance system. The facility's only infection documentation is incomplete and inaccurate testing results of residents and staff for COVID-19. There is no surveillance line list for any other infections. The facility did not produce their Infection Control and Infection Prevention Policies. (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 06/01/22 at 1:26 p.m., Surveyor interviewed Public Health (PH) H. Surveyor asked if facility had contacted Public Health related to any COVID-19 positive cases. PH H stated Director of Nursing (DON) B contacted PH H on 05/07/22 to inform public health of 5 residents who had tested positive. PH H stated DON B called again on 05/09/22 and reported 5 more residents who tested positive for COVID-19, and on 05/18/22 DON B reported one more additional resident who tested positive for COVID-19. Surveyor reviewed the May 2022 COVID-19 resident testing log. The log did not match what was reported to Public Health. The log stated 1 resident positive on 05/14/22, 4 residents positive on 05/11/22, and 4 residents positive on 05/18/22. The testing log is inaccurate not identifying ill residents on 5/7/22 and 5/9/22. The testing list is not an inclusive surveillance line list as it does not state what symptoms the residents had, what date isolation started, and the date the illness was resolved. Surveyor reviewed medical records and the resident log, in which there are no symptoms documented, no documentation if any of the residents who tested positive were asymptomatic. No documentation found or provided by the facility as to when isolation began for any of the residents that had been positive for Covid 19. Surveyor reviewed testing dates of residents and staff. Residents were tested for COVID-19 on 05/11/22 and 05/18/22 per COVID-19 log. Staff testing took place on each date the employee worked. Surveyor reviewed NHSN reporting. The facility reported 4 staff and 5 residents tested positive for COVID-19 the week ending 05/22/22. The resident testing log only states 4 residents testing positive on 05/18/22, and the employee testing log only states 1 employee testing positive on 05/11/22. There is no surveillance to coincide with the NHSN reporting results. On 06/01/22 at 8:50a.m., Surveyor interviewed DON (Director of Nursing) B. Surveyor asked about the surveillance of infections. DON B stated she is only one person and there is not enough staff. DON B stated she was told she is the infection preventionist and she does not know anything about infection control. No surveillance of infections was being conducted.

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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 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 31086 Based on record review and interview, the facility did not ensure an individual identified as the infection preventionist responsible for the facility infection control program had the necessary training or education in infection prevention and control. The facility's Director of Nursing (DON) was identified as the infection preventionist and did not have the necessary skills/training to implement an infection control program within the facility to include surveillance and testing. This is evidenced by: According to the Center for Medicare and Medicaid Services (CMS) 42 CFR 483 Requirements for Long Term Care Facilities: The facility must 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. (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to S483.70(e) and following accepted national standards; (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility. On 05/31/22, Surveyor reviewed facility's infection prevention and infection control surveillance. The facility produced no evidence of a daily or outcome surveillance system. On 06/01/22 at 8:50a.m., Surveyor interviewed DON (Director of Nursing) B. Surveyor asked about the surveillance of infections. DON B stated she is only one person and there is not enough staff. DON B stated she was told she is the infection preventionist and she does not know anything about infection control. No surveillance of infections was being conducted. (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 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Centers for Medicare and Medicaid Services (CMS) memo: Interim Final Rule (IFC), CMS-3401-IFC, Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency related to Long Term Care (LTC) Facility Testing Requirements, dated August 26, 2020, and revised on 03/10/22 states, in part: .Facilities must demonstrate compliance with the testing requirements. To do so, facilities should do the following: o For symptomatic residents and staff, document the date(s) and time(s) of the identification of signs or symptoms, when testing was conducted, when results were obtained, and the actions the facility took based on the results. o Upon identification of a new COVID-19 case in the facility, document the date the case was identified, the date that other residents and staff are tested , the dates that staff and residents who tested negative are retested , and the results of all tests (see section Testing of Staff and Residents During an Outbreak Investigation above). o For staff routine testing, document the facility's level of community transmission, the corresponding testing frequency indicated (e.g., every week), and the date each level of community transmission was collected. Also, document the date(s) that testing was performed for staff, who are not up-to-date, and the results of each test . On 06/01/22 at 8:50 a.m., Surveyor interviewed DON B and asked when the COVID-19 outbreak started. DON B stated the outbreak started on 05/11/22. Surveyor asked about R8 and R11 testing positive on 05/07/22 per documentation in their medical records. DON B stated they both tested positive on 05/11/22. Surveyor asked when the facility contacted Public Health regarding the outbreak. DON B stated she contacted them a couple of times but was not sure of the date. Surveyor asked if the facility had any PCR tests done. DON B stated the only tests performed were the rapid tests. DON B stated employees were testing almost daily until they were told too many supplies were being used, and to only test twice weekly. Surveyor asked if DON B knew about frequency of testing and what the frequency is based on. DON B stated she doesn't know anything about infection control and does not know exactly what needs to be done for testing or documentation. DON B did state the facility checked the county positivity rate, but otherwise DON B stated she didn't know.

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F 0886 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Perform COVID19 testing on residents and staff. 41945 Based on record review and interview, the facility did not conduct testing of facility staff and residents that is consistent with current standards of practice for conducting COVID-19 testing. This had the potential to affect 39 of 39 residents. *Incomplete of testing of staff or residents on date of 05/07/22, in which facility reported to Public Health of COVID-19 outbreak. *Frequency of testing for staff not per County Transmission Level. *Frequency of testing for residents not performed as per Center for Disease Control and Prevention (CDC) memo SARS-CoV-2 Antigen Testing in Long Term Care Facilities, updated as of February 17, 2022. *Facility did not ensure complete documentation in resident's record related to COVID symptoms, treatment, and testing results/date. Findings include: The Centers for Medicare and Medicaid Services (CMS) memo: Interim Final Rule (IFC), CMS-3401-IFC, Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency related to Long-Term Care (LTC) Facility Testing Requirements, dated August 26, 2020, and revised on 03/10/22 states, in part: .*A new COVID-19 infection in any staff or any nursing home-onset COVID-19 infection in a resident triggers an outbreak investigation. *In an outbreak investigation, rapid identification and isolation of new cases is critical in stopping further viral transmission. *Upon identification of a single new case of COVID-19 infection in any staff or residents, testing should begin immediately. *Routine testing of asymptomatic residents is not recommended unless prompted by a change in circumstances, such as the identification of a confirmed COVID-19 case in the facility. *Facilities should use their community transmission level as the trigger for staff testing frequency . (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 0886 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Centers for Medicare and Medicaid Services (CMS) memo: Interim Final Rule (IFC), CMS-3401-IFC, Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency related to Long-Term Care (LTC) Facility Testing Requirements, dated August 26, 2020, and revised on 03/10/22 states, in part: .Facilities must demonstrate compliance with the testing requirements. To do so, facilities should do the following: o For symptomatic residents and staff, document the date(s) and time(s) of the identification of signs or symptoms, when testing was conducted, when results were obtained, and the actions the facility took based on the results. o Upon identification of a new COVID-19 case in the facility, document the date the case was identified, the date that other residents and staff are tested , the dates that staff and residents who tested negative are retested , and the results of all tests (see section Testing of Staff and Residents During an Outbreak Investigation above). o For staff routine testing, document the facility's level of community transmission, the corresponding testing frequency indicated (e.g., every week), and the date each level of community transmission was collected. Also, document the date(s) that testing was performed for staff, who are not up-to-date, and the results of each test . On 06/01/22 at 1:26 p.m., Surveyor interviewed Public Health (PH) H. Surveyor asked if facility had contacted Public Health related to any COVID-19 positive cases. PH H stated Director of Nursing (DON) B contacted PH H on 05/07/22 to inform public health of 5 residents who had tested positive. PH H stated DON B called again on 05/09/22 and reported 5 more residents who tested positive for COVID-19, and on 05/18/22, DON B reported one more additional resident who tested positive for COVID-19. Surveyor reviewed the May 2022 COVID-19 resident testing log. The log did not match what was reported to Public Health. The log stated 1 resident positive on 05/14/22, 4 residents positive on 05/11/22, and 4 residents positive on 05/18/22. R9 is documented as testing positive on 05/11/22 and date resolved as 05/21/22, but R9 was discharged home from the facility on 05/11/22. R10 is documented as testing positive on 05/11/22 and date resolved as 05/21/22, but R10 was discharged home from the facility on 05/14/22. R9 is documented as testing positive on 05/11/22, but in R9's medical record it is documented the date of testing positive was 05/07/22. R11's medical record documented R11 testing positive on 05/07/22 and R11 was not listed on the resident COVID-19 log. R8 is documented on the resident COVID-19 log as testing positive on 05/11/22, but in R8's medical record documentation states R8 tested positive for COVID-19 on 5/07/22. Surveyor reviewed testing dates of residents and staff. Residents were tested for COVID-19 on 05/11/22 and 05/18/22 per COVID-19 log. Staff testing took place on each date the employee worked. Surveyor reviewed NHSN reporting. The facility reported 4 staff and 5 residents tested positive for COVID-19 the week ending 05/22/22. The resident testing log only states 4 residents testing positive on 05/18/22, and the employee testing log only states 1 employee testing positive on 05/11/22. The employee log shows many dates of employees having no result next to their name and date of testing. (continued on next page)

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F 0886 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 06/01/22 at 8:50 a.m., Surveyor interviewed DON B and asked when the COVID-19 outbreak started. DON B stated the outbreak started on 05/11/22. Surveyor asked about R8 and R11 testing positive on 05/07/22 per documentation in their medical records. DON B stated they both tested positive on 05/11/22. Surveyor asked when the facility contacted Public Health regarding the outbreak. DON B stated she contacted them a couple of times but was not sure of the date. Surveyor asked if the facility had any PCR tests done. DON B stated the only tests performed were the rapid tests. DON B stated employees were testing almost daily until they were told too many supplies were being used, and to only test twice weekly. Surveyor asked if DON B knew about frequency of testing and what the frequency is based on. DON B stated she doesn't know anything about infection control and does not know exactly what needs to be done for testing or documentation. DON B did state the facility checked the county positivity rate, but otherwise DON B stated she didn't know.

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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 0888 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure staff are vaccinated for COVID-19 31086 Based on observation, interview, and record review, the facility did not ensure that 100% of staff were fully vaccinated for COVID-19 or mitigation strategies were in place. This has the potential to affect all 39 residents. Certified Nursing Assistant (CNA) K working in the facility was not fully vaccinated and the facility was not following mitigation strategies for testing on a regular basis. The facility does not have a staff COVID-19 vaccination policy. This is evidenced by: Review of the facility's staff matrix identifies a current staff vaccination rate of 97.3% and is not at 100%. CNA K had received the first dose of Moderna vaccine on 05/23/22 and has not received the second dose. Review of the facility's NHSN reporting date of 05/15/22 documented staff vaccination at 89.2%. Review of the facility's infection control log for May identified 9 residents testing positive for COVID-19 with the last positive on 05/14/22. There were no hospitalization s related to Covid 19 diagnoses. Review of the facility's staff COVID-19 testing log does not identify CNA K as being tested . Review of the Centers of Disease Control (CDC) community transmission rate per county for the 05/11/22 to current identified the county at a High transmission rate. On 06/01/22 at 2:00 p.m., Surveyor interviewed Admissions Director (AD) L asking about CNA K's vaccination status. AD L indicated CNA K had started working in the facility after receiving the first dose of Moderna vaccine and will be getting the second dose when it is due. Surveyor verified CNA K received the vaccination on 05/23/22 and started working in the facility on 05/25/22. Surveyor interviewed Nursing Home Administrator (NHA) A asking about staff vaccination. NHA A indicated CNA K had just received the vaccine and started working. Surveyor reviewed with NHA A, CNA K is not fully vaccinated with the primary vaccine, and this would put the facility at 97.3% vaccinated and not at the required 100%. Surveyor reviewed with NHA A, CMS QSO 22-07-ALL-memo for staff vaccination. The facility did not have mitigation strategies identified nor in place for partially vaccinated CNA K. Surveyor requested the facility's staff COVID-19 vaccination policy. The facility was not able to provide a policy.