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	08/16/2022

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30570 Based on record review and interview, the facility did not consult the physician timely for 1 of 1 residents (R4) when R4 developed pressure injuries. R4 developed pressure injuries to his right and left feet. R4's physician was not consulted when the pressure injuries were noted, delaying treatment of the pressure injuries. Findings Include: R4 was admitted [DATE], after a lengthy stay in the hospital (01/16/2022 - 04/22/22) with diagnoses of toxic vs. metabolic encephalopathy/chronic alcohol/drug abuse, neuropathy in both lower extremities, UTI, pneumonia, and sepsis. R4 had a history of lumbar sprain, ankle sprain, ankle fracture, osteoarthritis of both hips, hip dysplasia, and necrosis of hips. R4's hospital discharge record notes pressure injuries in the hospital at R4's right great toe and 4th great toe that were unstageable and healed during his hospital stay. Surveyor reviewed R4's record which included skin assessments, nurses notes, and physician orders. Nurses' notes from admission to 05/22/22 show no issues with R4's skin. 05/22/22 Skin evaluation notes: left heel with unstageable pressure injury with Length (L)=4 x Width (W)=4.5, necrotic wound bed with heavy dressing saturation (75%), no odor, no tunneling, no undermining. There is no evidence R4's physician was consulted, and orders were not noted as changed until 05/25/22. 05/25/22 Nurses note: Request order change to left heel DTI (deep tissue injury), ischemic area top of left toe . MD with new orders. 05/25/22 Physician orders obtained for treatment of pressure injury as follows: ~Cleanse left heel ulcer with wound cleanser, pat dry, skin prep surrounding area, apply medi-honey to wound bed, cover aquacel, cover with adhesive foam, secure with kerlix and tape. Change Monday, Wednesday, and Friday and prn (as needed) ~ skin prep right and left outer ankles Monday, Wednesday, and Friday, and PRN (continued on next page)

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	~skin prep right heel DTI, cover with duoderm, change Monday, Wednesday, and Friday, and prn, if opens update MD ~skin prep right heel DTI, cover with duoderm, change Monday, Wednesdays, and Fridays, and prn, if opens/changes update MD. 05/27/22 Skin evaluation: blister left top of foot L=2x W=1, no odor, no tunneling, no undermining. Tissue painful. Provider Contacted: blank 06/01/22 (5 days after blister on left top foot was noted and 7 days after left great toe noted with ischemic area was noted) physician orders obtained as follows: skin prep left great toe distal ischemic area Monday, Wednesday and Fridays and prn, apply betadine to blister area every Monday, Wednesday, and Friday. 6/10/22 Skin evaluation: Pressure ulcer left heel unstageable, wound bed necrotic, wound exudate: serosanguineous, peri wound: WNL (within normal limits), dressing saturation: none, no odor, no tunneling, no undermining. Right heel suspected DTI depth unknown, no wound exudate, peri wound normal, no dressing saturation, no odor, no tunneling, no undermining. Anterior Left foot with no staging, no measurements or wound description. Provider contacted: blank. Record shows no evidence of MD consult until 06/14/22. 06/14/22: Physician orders obtained for gabapentin 300 mg QID (4 times a day) for neuropathy. 06/17/22 Nurses note - changed dressing to left heel and top of foot per wound orders. Resident has a scab on heel and around scab is purulent draining. This is a change in wound status and there is no evidence R4's physician was consulted until orders were obtained 06/21/22 for R4 to be seen at wound clinic. On 08/08/22 at 3:50 pm, Surveyor spoke with NHA A. NHA A indicated she had developed a past non-compliance plan related to timely and thorough pressure injury care and treatment, she was aware of concerns, and can only go forward from when she started. On 08/09/22 at 11:41 AM, Surveyor again spoke with NHA A. NHA A expressed the facility conducted a chart review of R4's pressure injuries. No additional information was found, no risk management was completed, nothing was documented, and appropriate follow up for R4's pressure injuries was not located.

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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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39713 Based on interview and record review, the facility did not have a system to ensure there was someone working each shift who was certified in CPR (cardiopulmonary resuscitation), which had the potential to affect 8 of 26 residents (R1, R2, R4, R6, R8, R9, R13, and R15) who are full code and wished to be resuscitated. On admission, R6's Advanced Directives indicates he wanted to be a full code. The facility's electronic charting system indicated R6 elected to be a DNR (do not resuscitate). R2, R4, R6, R8, R9, R13, and R15 all have Advanced Directives indicating their choice was to be a full code and they desired to have CPR (cardiopulmonary resuscitation) should they become unresponsive. There was no one in the building from 6:00 AM on [DATE] to 6:00 PM on [DATE] and from 6:00 PM to 6:00 AM on [DATE] and [DATE] who was CPR certified. Until survey, the facility could not readily determine if nurses who worked other shifts were CPR certified. CNA/Main/Transp I (Certified Nursing Assistant/Maintenance/Transportation) was transporting residents to appointments without current and up-to-date CPR certification. The facility's failure to ensure a CPR certified staff was working in the facility at all times and it's failure to ensure R6's record accurately identified R6's wishes/advance directives created a finding of immediate jeopardy that began on [DATE]. Surveyor notified NHA A on [DATE] at 2:16 PM. The immediate jeopardy was removed on [DATE]. The deficient practice continues at a scope/severity of E (potential for more than minimal harm/pattern) as the facility continues to implement its action plan. Findings include: The facility policy titled, Do Not Resuscitate Order, undated, states in part, .Our facility will not use cardiopulmonary resuscitation and related emergency measures to maintain life functions on a resident when there is a Do Not Resuscitate Order in effect. 2. A Do Not Resuscitate (DNR) order form must be completed and signed by the Attending Physician and resident (or resident's legal surrogate, as permitted by State law) and placed in the front of the resident's medical record . 6. The Interdisciplinary Care Planning Team will review advanced directives with the resident during quarterly care planning sessions to determine if the resident wishes to make changes in such directives. The facility policy titled, Emergency Procedure - Cardiopulmonary Resuscitation, undated, states in part . Policy Statement: Personnel have completed training on the initiation of cardiopulmonary resuscitation (CPR) and basic life support (BLS), including defibrillation, for victims of sudden cardiac arrest. Preparation for Cardiopulmonary Resuscitation: 1. Obtain and/or maintain a state approved BLS-CPR certification with skills check off in Basic Life Support (BLS)/Cardiopulmonary Resuscitation (CPR) for key clinical staff members who will direct resuscitative efforts, including non-licensed personnel. Example 1: (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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R6 was admitted to the facility on [DATE] with diagnoses that include respiratory failure with hypoxia, large B-cell lymphoma, history of pulmonary embolism, solitary plasmacytoma not in remission, and hypertension. R6 was a full code on admission. On [DATE] at 10:40 AM, Surveyor reviewed code status for R6. R6's Advanced Directives indicate he wished to be a full code. The facility's electronic charting system identified R6 as a DNR (Do Not Resuscitate). This contradicts R6's Advanced Directive. Hospital PPOC (Physician's Plan of Care) dated [DATE] indicates in part . No CPR. Hospital PPOC dated [DATE] indicates in part . No CPR. The facility did not verify with R6 his wishes of having CPR or being a DNR despite the differences in documentation. If R6 really wished to be DNR, his order would have been invalid because Wisconsin statute 154.19(1)(d) requires the signature of the patient, the guardian, or the health care agent. On [DATE] at 12:03 PM, Surveyor interviewed RN F. Surveyor asked RN F where she would look to find a resident's code status. RN F stated, I would look in computer charting. The computer charting would have indicated R6 did not want CPR even though he had elected to be a full code. On [DATE] at 9:36 AM, Surveyor asked NHA A for R6's signed DNR. NHA A stated, If it isn't in the chart, we don't have it. RN F was looking at this yesterday. She was going to take something down to R6 to have him sign. We should not be going off something that comes from the hospital for the code status. We would need to get something signed by the resident and physician. Example 2: Based on record review, R2, R4, R6, R8, R9, R13, and R15 all have Advanced Directives indicating their choice was to be a full code and they desired to have CPR should they become pulseless and non-breathing. On [DATE] at 9:18 AM, Surveyor requested copies of CPR certifications for the licensed nursing staff. On [DATE] at 11:50 AM, NHA A stated to Surveyor, I have been unable to find the CPR certifications, but they are here somewhere. Surveyor asked NHA A if all staff are required to be CPR certified. NHA A stated, All nurses but not CNAs (Certified Nursing Assistants). I just have been unable to locate the documentation. On [DATE] at 10:48 AM, Surveyor reviewed personnel files for NHA A, RN F, and RN K (these are the only licensed nursing staff for the facility). There is no evidence in any of the files indicating that the nurses are CPR certified. Following the survey, the facility was able to provide current and up-to-date CPR certifications for RN F and RN K but not for NHA A. Starting on [DATE] at 6:00 AM, NHA A, who is also an RN (Registered Nurse), worked as a floor nurse in the facility without leaving the building until [DATE] at 6:00 AM; NHA A was the only nurse in the building during these 84 hours. NHA A also worked on [DATE] and [DATE] from 6:00 PM to 6:00 AM during the night shift and was the only nurse in the building. NHA A did not have current CPR certification. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On [DATE] at 10:30 AM, Surveyor spoke with CNA/Main/Transp I who indicates he does a little bit of everything including taking residents out to appointments. Surveyors requested evidence that CNA/Main/Transp I was CPR certified. The facility was unable to provide that documentation. On [DATE] at 11:46 AM, Surveyor spoke with NHA A. Surveyor explained to NHA A the concern of R6's Advanced Directives indicating he wanted CPR, but the electronic charting system indicates R6 was a DNR. Furthermore, Surveyor explained that RN F indicated that the electronic charting system is where she would look to find a resident's code status. Surveyor also explained the concern that the facility has no record of their nursing staff's CPR certification and no system in place to keep track of CPR certification. The failure to ensure R6's wishes were accurately and consistently identified in the medical record and the failure to ensure CPR-certified staff worked each shift created a reasonable likelihood that serious harm could occur, thus creating a finding of immediate jeopardy. The facility removed the jeopardy on [DATE], when it had completed the following: 1. NHA A completed an audit of the 26 residents and found 2 residents to not have the EMR (electronic medical record) updated. On [DATE] the EMR was updated and reflected the correct Advanced Directive by the NHA A. 2. NHA A and all other licensed nurses will have their CPR recertification completed by [DATE]. 3. NHA A was reeducated by Nurse Consultant on [DATE] on ensuring the CPR certifications are maintained and that 1 person per shift must be certified to provide CPR in the event a resident would code on [DATE]. 4. All licensed nurses will be reeducated by [DATE] on ensuring they maintain their CPR status by NH A. 5. The Social Worker was reeducated by the NHA A on [DATE] on ensuring the advanced directives are addressed upon admission and readmission and the EMR reflects the status of the resident's wishes. 6. The Human Resource Department was reeducated on [DATE] by the [NAME] President of Operations on ensuring all licensed nurses have their CPR certification upon hire and renewed every 2 years thereafter. 7. The Human Resource (HR) Department will ensure the licensed nurses upon hire have the required CPR certification. The HR department will notify the employee 30 days prior to the expiration of the certification for renewal. Any employee that is not able to complete the re-certification will be removed from the schedule until the CPR certification is received by the facility. 8. The Social Worker will bring to the daily stand-up meeting the completed advanced directive audit for review by NHA A for further follow up as identified. 9. HR Director will bring the completed licensed nurse CPR audit to the stand-up meeting to ensure all nurses have or have recertified in CPR. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	10. The completed HR audit of CPR certification and recertification along with the Advanced Directive audit will be reviewed with the monthly QAPI committee monthly for 6 months for further follow up and recommendations as indicated.

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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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30570 Based on observation, interview, and record review, the facility did not put measures in place to prevent pressure injuries from developing, did not comprehensively assess pressure injuries, did not consult physician timely, and did not put measures in place to promote healing when 1 of 1 residents (R4) developed pressure injuries. R4 was admitted at risk for the development of pressure injury. The facility did not develop a care plan to address his risk factors. R4 developed pressure injuries that progressed to Stage IV. The facility did not comprehensively assess the pressure injuries, did not consult the physician timely, and did not put appropriate measures in place to promote healing of the pressure injuries. R4's pressure injuries got infected, requiring R4 to be hospitalized with a Stage IV pressure injury that required antibiotics and debridement. The facility's failure to put measures in place to prevent the development of a pressure injury and to promote the healing of pressure injuries created a finding of immediate jeopardy that began 05/22/22. Surveyor informed Nursing Home Administrator (NHA) A of the immediate jeopardy on 08/09/22 at 3:01 PM. The immediate jeopardy was removed on 08/16/22. However, the deficient practice continues at a scope and severity level D (potential for more than minimal harm that is not immediate jeopardy/isolated) as the facility continues to implement its action plan. Findings Include: R4 was admitted [DATE] after a lengthy stay in the hospital (01/16/22 through 04/22/22) with diagnoses of toxic vs. metabolic encephalopathy/chronic alcohol/drug abuse, neuropathy in both lower extremities, UTI (urinary tract infection), pneumonia, and sepsis. R4 had a history of lumbar sprain, ankle sprain, ankle fracture, osteoarthritis of both hips, hip dysplasia, and necrosis of the hips. R4's hospital discharge record notes resident at risk for skin integrity due to decreased sensory perception because of limited sensation and neuropathy, exposure to moisture because of urinary or fecal incontinence, and altered activity/mobility because of inability to reposition independently. Skin is intact. Pressure injuries were noted in the hospital on R4's right great toe and 4th great toe that were unstageable and healed during his hospital stay. R4's admission skin assessment dated [DATE] notes skin integrity is normal with no pressure injuries noted. R4's Braden Scales for Predicting Pressure Score Risk noted: ~ 04/22/22: (on admission) resident at risk for pressure injury (15). Risk factors of bedfast, limited mobility, and requires moderate to maximum assistance in moving were noted. Surveyor reviewed R4's care plan and noted R4's care plan did not address strategies to prevent recurrence of pressure injuries that were noted in the hospital or address the identified risk. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	~04/29/22 notes - resident now considered high risk for pressure injury (12). With risks of very limited sensory perception and moisture changed to very moist skin vs. rarely moist added. ~05/06/22, 05/13/22 and 05/20 notes resident remains high risk (10). Surveyor reviewed R4's Admission MDS dated [DATE] which notes R4 understands, is understood, and is cognitively intact. R4 does not reject care and has no mood or behavioral concerns. R4 required extensive assist of 2 for bed mobility and transfer. R4 was dependent on staff for bathing and toilet use. R4's range of motion is impaired in 1 upper extremity and both lower extremities. R4 was frequently incontinent of bladder and always incontinent of bowel. R4 had no pain and is on scheduled pain medications. R4 weighs 201 with no weight loss. R4 is at risk for pressure injury and had no pressure injury. R4's Nutritional Risk assessment dated [DATE] notes adding 1 oz of additional dietary protein at meals and 4 oz Ensure Plus at breakfast and supper due to recent skin impairment and variable intakes. Per nursing notes, skin is good with history of pressure injuries noted. R4's interim plan of care dated 04/22/22 simply states Skin integrity: Preventive Care. It instructs staff to check and change R4 every 2 hours and transfer with a Hoyer (mechanical lift). Nurses notes from admission to 05/22/22 show no issues with R4's skin. 05/22/22 Skin evaluation notes left heel with unstageable pressure injury with Length (L)=4 x Width (W)=4.5, necrotic wound bed with heavy dressing saturation (75%), no odor, no tunneling, no undermining. Care plan shows no updates related to skin integrity. 05/22/22 Nurses Note: Resident educated related to new order: no. Resident education provided related to new diagnosis: no. There is no evidence R4's physician was consulted, and orders were not changed with the development of a new pressure injury. 05/25/22 Nurses note: Request order change to left heel DTI (deep tissue injury), ischemic area top of left toe .MD with new orders. 05/25/22 Physician orders state: ~Cleanse left heel ulcer with wound cleanser, pat dry, skin prep surrounding area, apply medi-honey to wound bed, cover aquacel, cover with adhesive foam, secure with kerlix and tape. Change Monday, Wednesday and Friday and prn (as needed) ~skin prep right and left outer ankles Monday, Wednesday and Friday and PRN ~skin prep right heel DTI, cover with duoderm, change Monday, Wednesday and Friday and prn, if opens update MD ~skin prep right heel DTI, cover with duoderm, change Monday, Wednesdays and Fridays and prn, if opens/changes update MD. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Care plan shows no changes related to skin integrity. 05/27/22 Skin evaluation: blister left top of foot L=2x W=1, no odor, no tunneling, no undermining. Tissue painful. Provider Contacted: blank Care plan unchanged. 06/01/22 (5 days after blister on left top foot noted and 7 days after left great toe noted with ischemic area) Physician order: skin prep left great toe distal ischemic area Monday, Wednesday and Fridays and prn, apply betadine to blister area every Monday, Wednesday, and Friday. 06/03/22: Skin evaluation: Pressure injury left heel, unstageable: L, W, D: see notes (there are no notes from 05/29/22-06/09/22). Wound bed: slough, wound exudate: none, peri wound: erythema, dressing saturation: moderate, mushy. Pressure injury left big toe where nail meets skin, unstageable 0.1 x 0.1 x none, no odor, no tunneling, no undermining, no dressing saturation. 06/10/22 Skin evaluation: Pressure ulcer left heel unstageable, wound bed necrotic, wound exudate: serosanguineous, peri wound: WNL (within normal limits), dressing saturation: none, no odor, no tunneling, no undermining. Right heel suspected DTI depth unknown, no wound exudate, peri wound normal, no dressing saturation, no odor, no tunneling, no undermining. Anterior Left foot with no staging, no measurements or wound description (first mention of left anterior foot) concern. Provider contacted: blank. Record shows no evidence of MD consult until 06/14/22. 06/14/22: Physician order for gabapentin 300 mg QID (4 times a day) for neuropathy. No mention of treatment for right heel or anterior left foot. 06/17/22 Skin evaluation: No documentation related to wounds or wound descriptions. All blank. 06/17/22 Nurses note: changed dressing to left heel and top of foot per wound orders. Resident has a scab on heel and around scab is purulent draining. 06/21/22: Nurses Note: New order: Can be seen at wound clinic. Appointment at MCLC Thursday 06/23/22 at 11:20 06/23/22 Wound Clinic Note (Initial visit): (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Medical History: Neuropathy, wheelchair bound due to hip dysplasia, long term hospitalization (3 months) ICU related to Covid. Examination: Wound #1: pressure, left heel Measurements: 3.3 x 2.7 x depth 0.6 No undermining, no tunneling Wound bed: adherent eschar with softened edges, was removed to reveal slough tissue with granulation on the periphery. Edges: irregular Peri wound skin: intact without erythema or maceration Exudate: moderate serosanguineous drainage Odor: none Edema: none Pain: none Wound #2: Pressure, left dorsum foot Measurements: L=1.7 x W=1.8 x D=0 No undermining, no tunneling Wound bed: Granulation tissue with some adherent slough Edges: irregular Peri wound skin: intact without erythema or maceration Exudate: moderate serous drainage Edema: none Pain: none Procedure: Wound and surrounding area cleansed with wound cleanser and normal saline and patted dry. Slough and necrotic eschar were debrided using Adson's and iris scissors. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Primary dressing: medi-honey Secondary dressing: foam adhesive dressing Assessment: pressure injury left heel stage 3, friction injury to skin Plan: debridement of bilateral wounds was recommended and performed in office today. Medi-honey will be placed to continue to promote autolytic debridement of the wound beds .follow up in 1 week. If he has not made significant progress, we will consider culturing the wounds to determine if infection is the cause for delayed wound healing. 06/23/22 Wound Clinic Orders: Lower extremity wounds 1. Removal dressing, discard 2. Cleanse wounds and surrounding skin with normal saline or wound cleanser, pat dry 3. Apply Medi honey to wound beds 4. Apply foam adhesive dressing Change dressing every 2 to 3 days or more frequently for saturation or dislodgement. Scheduled for follow up 06/30/22. 06/24/22 Skin evaluation: Left heel unstageable pressure injury, necrotic wound bed, Serosanguineous wound exudate, normal peri wound, moderate dressing saturation, mushy, boggy. No measurements. Anterior Left foot, no measurements, no staging, moderate dressing saturation, normal peri wound, wound exudate: serosanguineous Right heel DTI with no tunneling, odor or undermining. 06/27/22: New order per RD (Registered Dietician) notes: recommendation for arginaid BID to promote wound healing. Care plan Date Initiated: 06/27/22: Focus: Resident has pressure injury to left heel and anterior left foot, right heel: Goal: resident pressure ulcer will show no signs of healing and remain free of infection. Interventions: ~Heels up device while in bed ~Monitor dressing to ensure it is intact and adhering, report loose dressing to treatment nurse (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	~Monitor nutritional status, serve diet as ordered, monitor intake and record ~Monitor/document/report prn any changes in skin: appearance, color, wound healing, s/s of infection, wound size (LxWxD) stage ~Obtain and monitor lab and diagnostics work as ordered. Report results to MD and follow up as indicated ~Administer treatments as ordered and monitor effectiveness. ~Assess/record/monitor wound healing, measure; length, width, and depth where possible, assess and document status of wound perimeter, wound bed and healing progress, report improvements/decline to MD 06/30/22 Wound clinic notes: Examination: Wound #1: pressure, left heel Measurements: 3.0 x 2.7 x depth 0.4 No undermining, no tunneling Wound bed: adherent slough with adipose tissue Edges: irregular Peri wound skin: intact without erythema or maceration Exudate: moderate serosanguineous drainage Odor: none Edema: none Pain: none Wound #2: Pressure, left dorsum foot Measurements: L=1.2 x W=1.4 x D=0 No undermining, no tunneling Wound bed: Granulation tissue with exposed tendon Edges: irregular (continued on next page)

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	08/16/2022

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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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Peri wound skin: intact without erythema or maceration Exudate: moderate serous drainage Edema: none Pain: none Procedure: Wound and surrounding area cleansed with wound cleanser and normal saline and patted dry. Aerobic cultures of left heel obtained Slough and eschar were debrided Primary dressing: Xeroform Secondary dressing: foam adhesive dressing Assessment: pressure injury left heel stage 3, friction injury to skin 06/30/22 Wound Care Orders: Left anterior ankle: 1. Remove old dressing and discard 2. Cleanse wound and surrounding skin with saline or wound cleanser and pat dry 3. Apply collagen dressing such as Prisma to wound bed 4. Apply foam adhesive dressing Change dressing every 3 days or more frequently for saturation of dislodgement Left heel: 1. Remove old dressing and discard 2. Cleanse wound and surrounding skin with saline or wound cleanser and pat dry. 3. Apply Xeroform to wound bed 4. Apply foam adhesive dressing. 5. Ensure no pressure is applied to heels at any point. The heel should remain floating off of any surface. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Change dressing every 2-3 days of more frequently for saturation of dislodgement. Next appointment 07/06/22 07/01/22 Skin evaluation: Left heel: Noted as Unstageable with no measurements, slough, normal peri-wound, moderate dressing saturation, no tunneling, no undermining and no odor Anterior left foot, unstageable with slough and serosanguineous wound exudate serosanguineous, peri wound normal, moderate dressing saturation, no odor, no tunneling and no undermining. Right heel DTI, no tunneling, no odor, no undermining. 07/06/22 Skin evaluation: Left heel: Unstageable, Measurement's state: 2.9 x 2.9 with depth unmeasurable d/t (due to)slough, normal peri-wound, moderate dressing saturation, no odor, no undermining or tunneling Anterior left foot Now noted as a stage IV measuring 0.9 x 1.3 x 0 with granulation and serosanguineous wound exudate. Right heel now noted as pressure ulcer and DTI measuring 0.5 x 0.5, no description of wound bed, normal peri wound, no odor, no tunneling or undermining. Skin note: left heel depth unmeasurable r/t bed wound slough-100%, wound edges irregular, left anterior foot ulcer 50% granulation and 50% tendon exposed, wound edges irregular, Right heel-DTI scattered dark purple, New orders obtained from wound clinic, seen today. 07/06/22 Wound clinic notes: Extremities: patient's right foot is slightly cooler than his left foot. He has 2 wounds present on his left foot. There is one wound on the dorsum of his foot and one wound on the posterior heel. His ankle is in a fixed plantar flexion position. He has trace edema. Bilateral ankles are extremely plantar flexed with curling of his toes. Wound #1: pressure, left heel, Stage IV Measurements: 2.9 x 2.1 x depth 0.9 No undermining, no tunneling Wound bed: soft yellow slough tissue Edges: irregular Peri wound skin: intact without erythema or maceration Exudate: moderate serosanguineous drainage (continued on next page)

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	525678	A. Building B. Wing	08/16/2022

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Odor: none Edema: none Pain: none Primary dressing: gauze slightly moistened with normal saline Secondary dressing: 4 x 4 gauze secured with gauze roll Wound #2: Pressure stage IV left dorsum foot Measurements: L=0.9 x W=1.3 x D=0 No undermining, no tunneling Wound bed: 50% hypertrophic granulation tissue, 50% exposed tendon Edges: irregular Peri wound skin: intact without erythema or maceration Exudate: moderate serous drainage Edema: none Pain: none Primary dressing: Xeroform gauze Secondary dressing: gauze roll 07/11/22 Wound Clinic note: Peripheral pulse regular of left foot but not palpable on right foot Extremities: The right lower extremity is very warm to touch from the foot to below the knee. He has 2 wounds present on left foot. There is one wound on the dorsum of foot and one wound on his posterior heel. His ankles are in a fixed plantar flexion position. He has trace edema. Bilateral ankles are extremely plantar flexed with curling of his toes. Wound #1: pressure, left heel, Stage IV Measurements: 2.9 x 2.0 x depth 0.5 No undermining, no tunneling Wound bed: mostly granular tissue, boggy. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Edges: irregular Peri wound skin: intact without erythema or maceration Exudate: moderate serosanguineous drainage Odor: none Edema: none Pain: none Primary dressing: gauze slightly moistened with normal saline Secondary dressing: 4 x 4 gauze secured with gauze roll Wound #2: Pressure stage IV left dorsum foot Measurements: L=2.0 x W=2.1 x D=0 No undermining, no tunneling Wound bed: 50% hypertrophic granulation tissue, 50% exposed tendon Edges: well, defined, attached Peri wound skin: deep tissue pressure injury superiorly Exudate: moderate serous drainage, active bleeding Edema: none Pain: none Primary dressing: Prisma Secondary dressing: dressing with adhesive border Plan: patient is chilled and has an elevated temperature (100.1F), low blood pressure (106/65) and elevated heart rate, pulse (90). His left lower extremity is very warm to touch. There is erythema and warmth around his wounds. This is concerning for sepsis. Laboratory studies recommended. Patient has leukocytosis and elevated CRP. Procalcitonin is pending. Patient's case discussed with MD from MMC Minocqua inpatient floor. Agreed to admit patient for sepsis due to pressure injuries of left leg. Recommend blood cultures, lactate level and COVID swab. General surgery service will follow patient while hospitalized . Hospital notes and discharge summary notes: (continued on next page)

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	525678	A. Building B. Wing	08/16/2022

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	admitted : 07/11/22 Discharge Diagnosis: 1. Infected pressure ulcer 07/11/22 2. Sepsis 07/11/22 3. Immobility 4. Anticoagulated 5. Neuropathy HPI: Patient admitted via the wound care clinic .hospitalized January-April of this year for pneumonia, complicated by sepsis .Today when he came into the wound clinic, he was noted to have a low-grade fever of 100.1. Heart rate 90, blood pressure 106/65. CBC showed leukocytosis with WBC 17.6 CRP was elevated 8.3. Procalcitonin was not elevated as it was less than 0.05. Source of leukocytosis and possible sepsis was felt to be infected pressure ulcers on left heel and dorsum of the left foot. admitted for further evaluation and treatment. It is felt he would need IV antibiotics and wound debridement. Exam: patient is alert and oriented x3 .Right lower extremity is very warm to touch from the foot to below knee, 2 wounds present on left foot. One on dorsum of foot and one on heel. Ankles in fixed plantar flexion. Skin: 2 pressure ulcers: 1 stage IV pressure to left heel with some serosanguineous drainage and second Stage IV to dorsum of left foot with tendon exposed and serous drainage. Assessment/Plan: Infected pressure injury, sepsis. Placed on vancomycin and cefepime while we await cultures. Surgery is planning to do possible debridement. 07/11/22: Start cefepime, 2 GM (gram)=20ml (milliliter) total volume=100, IV piggyback Q (every) 8 hour, infuse over 4 hours, first dose stat. Vancomycin=1GM=200ml total volume (ml) 200, IV piggyback Q 12 hours, infuse over 60 minutes: start 07/13/22 07/14/22 progress notes: Wound 1: Stage IV left heel, measurement 2.9x 2.7x0.57 mostly granular tissue, less slough, irregular wound beds. Peri wound intact without erythema or maceration, exudate moderate serosanguineous draining, dressing: primary: granufoam, secondary: transparent tape. Wound 2: Pressure stage IV left dorsum of foot measuring 3.4x 3.0x0.4 exposed tendon and hemorrhagic tissue, peri wound: deep tissue injury, exudate: serous drainage and active bleeding. Primary dressing: Prisma, secondary: dressing with adhesive foam. (continued on next page)

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	525678	A. Building B. Wing	08/16/2022

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Negative pressure wound therapy: non-disposable KCl wound VAC system applied .Negative pressure therapy continued at 125 mmHg. Assessment plan: cellulitis of left foot with associated left ankle and left heel wounds complicated by sepsis. Wound vac .Cefepime and Vanco for antibiotics .Plan to discharge tomorrow with wound VAC. Wound culture: gram stain with moderate GCP in pairs with moderate GNR. Gram plus cocci in pairs and gram-rods. Operative report: 07/12/22 Procedure: Debridement of left foot pressure ulcer down to the tendon (3.4x3x0.4). Debridement of left heel pressure ulcer down to deep fat (2.8x2.9x0.7). On admission was on Apixaban thus debridement was deferred to today. He tells me his legs are profoundly weak, but he is able to move them. No radiographic evidence of osteomyelitis .Following debridement wound vac placed. 07/15/22: discharged back to facility with orders: Left heel: remove old dressing cleanse wound and surrounding skin with saline or wound cleanser, apply skin barrier prep to skin surrounding the wound, apply transparent drape to skin surrounding wound to the dorsum of the foot, displace the [NAME] pad to the dorsum of the foot, change dressing M, W, F or more frequently for dislodgement. Left ankle: remove old dressing and discard, cleanse wound and surrounding skin with saline or wound cleanser, apply Prisma to wound bed, cover with foam adhesive dressing, change dressing every 2-3 days of more for saturation or dislodgement. Amoxicillin Clavulanate 875/125mg every 12 hours for 5 days Doxycycline 100 mg bid for 5 days Follow up in one week. Care plan with date initiated 07/15/22 (readmission from hospital) ~Air mattress setting #3 ~W/C (wheel chair) cushion Care plan with date initiated: 07/16/22: Doesn't like to reposition in bed. Risks and benefits explained, and he states understanding. Needs encouragement. Care plan with date initiated: 07/19/22: ~follow wound vac orders and follow up with wound clinic as needed (continued on next page)

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	525678	A. Building B. Wing	08/16/2022

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 08/05/22 at 8:14 AM, Surveyor spoke with R4. Resident indicated he believes the pressure injuries are from neuropathy, foot drop, and staff not elevating his feet at first. Further stating he did not have an air mattress or heels up pad. Surveyor observed R4's heels sitting on heels up pad. R4's heels were not floating over the device. R4 was lying flat on back on air mattress. On 08/05/22 at 9:04 am, Surveyor spoke with NHA A who verified resident has an air mattress set at 3. She was unsure when it was initiated/just went and made sure on care plan. On 08/08/22 at 9:28 am, Surveyor spoke with R4 who indicated he had a lengthy stay in the hospital, over 3 months, before coming to the nursing home. R4 indicated he was quite sick and depended on staff assistance for all bed mobility/transfers. R4 expressed having neuropathy in feet with the inability to feel his feet well. R4 expressed he moves his feet around in bed but is not sure why. R4 expressed his wounds are now improving since his hospital stay and the addition of the wound vac, air mattress, and device to float his heels. R4 expressed the air mattress was not placed until after his hospital stay and the heel floating device was not added until he started going to the wound clinic. R4 expressed his heels were flat on the bed prior to the device. R4 further expressed his pressure injuries are from his feet laying flat on the bed. Surveyor observed the air mattress with proper setting, heels up device with resident's feet floating and wound vac in place with clean dressing dated 08/06/22. Surveyor asked R4 about his toileting schedule. R4 expressed he can tell when he has been incontinent of bladder and bowel. He turns on his call light for staff to come in and change him. R4 expressed this is usually twice per shift. (Staff coming in when R4 turns on his call light twice a shift to be changed is not consistent with his care plan to check and change every 2 hours). On 08/08/22 at 2:02 pm, Surveyor spoke with Certified Nursing Assistant (CNA) M who has been on staff [AGE] years and is familiar with R4. CNA M indicated resident is reliable in his reporting. CNA M confirmed R4 did not have an air mattress until his return from the hospital on 07/15/22. CNA M further indicated she believes resident did not have a heels up device until he started seeing the wound clinic. Staff attempted to elevate/float resident heels using a pillow until he went to wound clinic. The pillows did not properly elevate resident's legs enough to float his heals from bed, which is how he got the pressure injuries to his heels. CNA M expressed R4's pressure injury on the top of his foot may be due to deformity of his feet with his other foot and resting it on top of his foot with the pressure injury. Expressing if his foot was left laying on top of his left ankle/foot for long periods of time it would cause a pressure injury. On 08/09/22 at 11:41 AM, Surveyor again spoke with NHA A. NHA A expressed the facility conducted a chart review of R4's pressure injuries. No additional information was found, no risk management was completed, nothing was documented, and appropriate follow up for R4's pressure injuries was not located. Further stating the staff involved are all gone. The failure to put measures in place to prevent the development of a pressure injury and to promote the healing of pressure injuries created a finding of immediate jeopardy that began 05/22/22. The facility removed the immediate jeopardy on 08/16/22 when it had completed the following: 1. Work closely, on a weekly basis, with the Wound Care Center to ensure proper measurement, staging, and treatment is conveyed related to R4. (continued on next page)

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	525678	A. Building B. Wing	08/16/2022

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. To ensure wound care is documented correctly and that the wound care orders are followed under the direction of the wound care provider and attending physician. 3. The administrator/RN will provide coordination of care between the resident's Wound Care provider and attending provider. 4. The resident plan care was updated with the correct problem, goal, and interventions by the wound care nurse on 08/09/22. 5. All residents will have a head-to-toe skin assessment completed by the Certified Wound Care Nurse. Any identified skin care issues will be reviewed with the resident's attending physician and orders received and processed to the TAR if warranted. All resident weekly skin assessment will be completed within 7 days each week and scheduled for the Wound Care Nurse to complete daily going forward. 6. The residents' plan care was updated with the correct problem, goal, and interventions by the wound care nurse. 7. The Director of Nursing will review the weekly skin assessments during the weekly risk assessment meeting to determine the status of each wound and interventions to promote healing. Any identified area not healing as planned will have a referral made to the wound care clinic for further follow up treatment as warranted. 8. The wound care nurse was reeducated on ensuring the residents receive a head-to-toe assessment at a minimum of 7 days. Any identified area of concern will be reported to the physician and orders implemented for the treatment or preventative to deter skin break down. 9. The Wound Care Physician was notified of the head-to-toe assessment on all residents and the physician will assess each and provide physician orders for treatment. These orders will be transcribed by the wound care nurse and entered on the TAR. 10. The Director of Nursing will review the head-to-toe skin assessment daily; wounded resident weekly; and during the weekly at-risk meeting to ensure the proper treatment was followed as prescribed by the physician and treatments are being followed on the TAR. 11. The wound care nurse will be educated on obtaining the wound care physician documentation to ensure continuity of care and treatment by the Wound Care Physician ensuring that these orders are reviewed, implemented, and followed through on the TAR.

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	525678	A. Building B. Wing	08/16/2022

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39713 Based on observations, interviews, and record reviews, the facility did not provide sufficient staffing to meet the needs of 26 of 26 residents living in the facility. On 08/04/22 and 08/05/22, during a complaint survey, the state survey agency noted the facility did not have a DON (Director of Nursing). The facility was not providing supervision to an RN (registered nurse) who has license restrictions that included direct supervision. The NHA (Nursing Home Administrator), who is also a nurse, was working as a floor nurse as many as 84 hours in a row without leaving the facility. The NHA was also noted to be sleeping in the therapy room at night during the 84 hours without relief. While the NHA slept, there was only one or two certified nursing assistants caring for resident needs. The failure to provide adequate staffing created a finding of immediate jeopardy that began on 08/05/22. The NHA (Nursing Home Administrator) A and VP (Vice President) C were notified of the immediate jeopardy on 08/05/22 at 2:25 PM. The immediate jeopardy was removed on 08/15/22, however the deficient practice continues at a scope/severity of an F (potential for more than minimal harm/widespread). This is evidenced by: A review of the facility assessment dated [DATE] indicates that the number of hours of licensed nurses and CNAs needed to ensure there is sufficient staff to meet resident needs is 72 hours per day. On 08/04/22 at 5:40 AM, Surveyor completed entrance with NHA/RN A. NHA/RN A stated, We currently do not have a DON. She quit on the spot on 07/28/22 without giving any notice. We are working on getting a replacement. The DON's last working day was 07/27/22. Corporate has been working on a contract with someone, but I am not sure where that is at. If I need anything I can call NC D (Nurse Consultant). Surveyor asked NHA/RN A if they had appointed anyone to be the interim DON. NHA/RN A stated, We have not appointed anyone at this time, no one wants to do it. RN F would do it but is unable to do so as she has restrictions on her license. On 08/04/22, at 5:19 AM, Surveyors were told the census was 26. Surveyors toured the building to determine the nurse and CNA (Certified Nursing Assistant) staffing levels. There was 1 RN who is also the NHA, and 2 CNAs. Surveyors requested the Daily Assignment Sheets and schedules beginning on 07/01/22. A review of the actual hours worked revealed the following: 07/28/22: 74 hours worked that day by direct care staff (licensed nurses and CNAs). This included 18 hours worked by the NHA/RN A (6AM to midnight). 07/29/22: (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	52 hours worked that day by direct care staff. This included 24 hours worked by the NHA/RN A. This is 20 hours (30%) below the minimum number of hours the facility determined was necessary to meet resident needs. (Note: from 6:00 AM to 2:00 PM and from 10:00 PM to 6:00 AM, there was only 1 CNA to care for 26 residents. The facility notes they have 7 residents that need assistance of a full body lift that requires 2 staff to safely operate.) 07/30/22: 64 hours worked that day by direct care staff. This included 24 hours worked by the NHA/RN A. This is 8 hours below the minimum number of hours the facility determined was necessary to meet resident needs. NHA/RN A worked the following hours and was the only nurse on duty from 07/28/22 at 6:00 AM until 07/31/22 at 6:00 PM. (Note: NHA/RN A worked a total of 84 hours straight between 07/28/22 and 07/31/22.) NHA/RN A worked on 08/01/22 from 6:00 AM to 6:00 PM and 08/03/22 from 6:00 PM to 6:00 AM on 08/04/22. Note: NHA/RN A did not leave on 08/04/22 at 6:00 AM due to Surveyors being in the facility. NHA/RN A worked 08/04/22 from 6:00 PM to 11:30 AM on 08/05/22 Note: NHA/RN A did not leave on 08/05/22 at 6:00 AM due to Surveyors being in the facility. RN F did not show up for her shift until 11:30 AM on 08/05/22. NHA/RN A worked a total of 17.5 hours without leaving the building between 08/03/22 and 08/05/22. At the time of this complaint survey, the facility employed a total of 3 Nurses, one which has restrictions on her license that requires her to have direct supervision, second is the NHA who is also an RN, and the third is the staff development coordinator. On 08/05/22 at 7:10 AM, Surveyor spoke with NHA/RN A. Surveyor asked NHA/RN A if she had left on 08/04/22 after Surveyors left the building. NHA/RN A stated, No, I ended up staying through the night shift as there was no one to relieve me. I only got about an hour of sleep. On 08/04/22 at 5:30 AM, Surveyor interviewed CNA G (Certified Nursing Assistant). Surveyor asked CNA G if she had worked with NHA/RN A between 07/29/22 and 07/31/22. CNA G stated, Yes, the nurse was available. I was to wake her up if I needed her. I did wake her once. She was not asleep the whole night. None of the residents had to wait for medications and there were no falls. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	One of the three nurses who work at the facility is RN F. RN F requires direct supervision (another nurse present in the building) while working in accordance with her license restrictions. It was determined that this RN worked as the only nurse in the building on the following dates without the supervision her license requires: 07/02/22, 07/03/22, 07/04/22, 07/09/22, 07/10/22, 07/23/22, 07/24/22, 08/06/22, and 08/07/22. On 08/04/22 at 7:50 AM, Surveyor interviewed RN F. RN F stated, There is always someone here acting as the charge nurse, NHA, DON, for RN K. If no one else is here, like on the weekend, I am the charge nurse. On 08/05/22 at 9:00 AM, Surveyor interviewed NHA/RN A. Surveyor asked NHA/RN A if she was aware RN F had restrictions on her RN license: NHA/RN A stated, The previous DON stated she needed to send in quarterly reports. That was all I knew. I have not read her restrictions. On 08/05/22 at 9:14 AM, Surveyor interviewed CHR L (Corporate Human Resources). Surveyor asked CHR L about RN F's license restrictions. CHR L stated, Our clinical team, including the DON and Corporate Team, reviewed RN F's restrictions. I knew she needed some type of supervision. VP C (Vice President) and NC D (Nurse Consultant) would have reviewed those restrictions. On 08/05/22 at 9:25 AM, Surveyor interviewed NC D. Surveyor asked NC D if he had reviewed RN F's RN license restrictions. NC D stated, I read the limitations on her license. I understood them as she had no limitations to practice but needed to be observed. She would then be reviewed by licensing in March of 2023. She had no more issues with narcotics, and I believed her oversight would be by the Board of Nursing. Surveyor asked NC D if he had asked DSPS (Department of Safety and Professional Services) to explain RN F's restrictions. NC D stated, I never contacted them to clarify her restrictions. I thought everyone would have reviewed her restrictions. RN F should have been supervised. Surveyor asked if VP C knew about RN F's restrictions. NC D stated, I am unsure if VP C knew about RN F's restrictions. I am not involved in the hiring process unless they have questions. Surveyor asked NC D when he was made aware of RN F's restrictions. NC D stated, I was made aware one week ago due to a discussion of making RN F the DON. During that discussion NHA/RN A indicated that RN F had a limited license. No one ever said she needed direct supervision. On 08/05/22 at 9:49 AM, Surveyor interviewed VP C. Surveyor asked VP C when he was made aware of RN F's license restrictions. VP C stated, I was made aware in March 2022 that she needed a licensed individual in the facility when she was working the medication cart. They wanted her to be the DON at one time and we discussed her restrictions then. Surveyor asked VP C if NHA/RN A was aware of RN F's license restrictions. VP C stated, I told the NHA that RN F needed to be supervised. NHA/RN A and I spoke and discussed it could be the NHA or someone in a supervisory capacity. We have had no issues with RN F. The DON walked out and the NHA and I discussed again the possibility of RN F taking over the DON role. Surveyor asked VP C about RN F's restrictions and if he was aware of the duration of those restrictions. RN F stated, The incident occurred in 2019 and signed in 2021. Surveyor asked VP C if he was aware RN F was working without supervision. VP C stated, I was aware she was working as the only nurse at times. We have had zero issues with her performance. We also felt that resident care was more important than supervision. I realize she should have been supervised. (continued on next page)

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	08/16/2022

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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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 08/05/22 at 11:46 AM, Surveyor spoke with NHA A. Surveyor explained to NHA A the concern of working several days in a row without leaving the facility, along with sleeping during part of those shifts in the therapy room while being the only licensed nurse in the facility. The concern of RN F working without the supervision her license required, and having only 1 CNA on a shift when several residents required two staff assist with a full body lift. The failure to ensure adequate staffing to meet resident needs created a reasonable likelihood that serious harm could occur, thus leading to a finding of immediate jeopardy. The facility removed the jeopardy on 08/15/22, when it had completed the following: 1. NHA/RN A was inserviced on ensuring the appropriate qualified nursing staff on 08/04/2022 by the VPO (Vice President of Operations). 2. An interim Director of Nursing on 08/05/2022 and began on 08/11/2022. 3. RN F will no longer serve as a nurse at the facility as of 08/10/2022. The facility will be covered by a licensed nurse to ensure the well being of the residents is monitored and maintained. 4. The staffing patterns will be based upon the in-house census and the desire is to meet the minimum staffing hours necessary to meet the needs of the residents illustrated in the facility assessment. Therefore 1 nurse to 30 residents per shift regardless of 8 hours or 12 hours shifts. 1 Certified Nursing Assistant to 15 residents on days, evenings. The midnight shift is dependent upon the acuity level of the residents and the maximum is 1:30 residents. 5. Facility has increased the nurse wages, offered retention bonuses, and increased the radius of the help wanted ads. 6. An RN MDS Coordinator, Interim Director of Nursing, and other RNs have been hired but they do not begin til after their required 2 week or 30 day notices. After 08/27/22 the facility will be fully staffed (if no changes to the current hires) with licensed nurses. 7. The schedule after 08/12/22 is currently under review by the VPO, Nurse Consultant, NHA A and the DON. NHA A and Interim DON were inserviced on ensuring the nurses do not work excessive hours during the day. 8. The facility assessment will be revised to illustrate the staffing patterns to meet the physical and psychosocial well being of the residents 08/08/22. 9. The staffing contingency plan was updated. 10. The RN Consultant will be at the facility on 08/09/22 to ensure the facility staffing is appropriate for the physical and psychosocial well being to be maintained. The corporate office will ensure a corporate nurse representative is at the facility weekly to support the facility. 11. The VPO will be at the facility on 08/10/22 to further assist with ensuring the physical and psychosocial well being of the residents is maintained.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 39713 Based on interviews and record review, the facility did not ensure full time DON (Director of Nursing) coverage. This has the potential to affect all 26 residents. DON B resigned effective 07/28/22. Facility did not replace the DON or have the staff to appoint a DON to the position. This is evidenced by: On 08/04/22 at 5:40 AM, Surveyor met with the NHA A (Nursing Home Administrator) for an entrance conference. NHA A stated in the conference that the facility has no DON at this time. The previous DON had quit on the spot without any notice on 07/28/22 and the facility is working on getting a replacement. On 08/05/22 at 8:25 AM, NHA A showed Surveyor a copy of a text message received from the previous DON which states, I don't think I can work tonite [sic]. I'm not coming back. You're right. Too many lies. My health is more important right now. I have to take care of myself. You should do the same. They r [sic] going to close. My family is on my back to leave. So I am going to do what I need to do for me. I can't risk not walking because I'm pushed to work. The DON resigned from the facility on 07/28/22 effective immediately. The facility has not had an acting DON since 07/28/22. On 08/05/22 at 8:26 AM, NHA A stated, I bent over backwards to make her happy. I needed someone to work third shift because I needed to be in the building during the day as the NHA. She was not happy about that. On 08/05/22 at 2:38 PM, Surveyor met with NHA A and VP C. VP C indicated that he was going to be in the role of the NHA and the NHA A would become the DON until they can find a replacement. On 08/05/22 at 5:41 PM, Surveyor received an email from VP C that a Regional RN would be coming to take the place of the DON and NHA A would remain in the role of the NHA.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41994 Based on observation, interview, and record review, the facility administration did not ensure residents received care and services to promote quality of life and ensure 26 of 26 residents (R) maintained their highest practicable level of physical, mental, and psychosocial well-being. NHA was filling multiple roles of NHA, DON, and RN providing direct care for residents. NHA was not able to work full time in the role of Administrator, thus was unable to ensure systems were put in place to address concerns related to resident pressure injuries, notification of changes, and CPR. This is evidenced by: NHA: On [DATE], at 5:19 AM, Surveyors were told the census was 26. Surveyors toured the building to determine the nurse and CNA (Certified Nursing Assistant) staffing levels. There was 1 RN who is also the NHA, and 2 CNAs. Surveyors requested the Daily Assignment Sheets and schedules beginning on [DATE]. A review of the actual hours worked revealed the following: NHA/RN A worked the following hours and was the only nurse on duty from [DATE] at 6:00 AM until [DATE] at 6:00 PM. (Note: NHA/RN A worked a total of 84 hours straight between [DATE] and [DATE].) NHA/RN A worked on [DATE] from 6:00 AM to 6:00 PM and [DATE] from 6:00 PM to 6:00 AM on [DATE] Note: NHA/RN A did not leave on [DATE] at 6:00 AM due to Surveyors being in the facility. NHA/RN A worked [DATE] from 6:00 PM to 11:30 AM on [DATE] Note: NHA/RN A did not leave on [DATE] at 6:00 AM due to Surveyors being in the facility. RN F did not show up for her shift until 11:30 AM on [DATE]. NHA/RN A worked a total of 17.5 hours without leaving the building between [DATE] and [DATE]. At the time of this complaint survey, the facility employed a total of 3 Nurses, one which has restrictions on her license that requires her to have direct supervision, second is the NHA who is also an RN, and the third is the staff development coordinator. On [DATE] at 7:10 AM, Surveyor spoke with NHA/RN A. Surveyor asked NHA/RN A if she had left on [DATE] after Surveyors left the building. NHA/RN A stated, No, I ended up staying through the night shift as there was no one to relieve me. I only got about an hour of sleep. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 5:30 AM, Surveyor interviewed CNA G (Certified Nursing Assistant). Surveyor asked CNA G if she had worked with NHA/RN A between [DATE] and [DATE]. CNA G stated, Yes, the nurse was available. I was to wake her up if I needed her. I did wake her once. She was not asleep the whole night. None of the residents had to wait for medications and there were no falls. Because NHA/RN A was working as a floor nurse during this time, there was no one functioning as the nursing home administrator. Because NHA/RN A was not functioning as the administrator, there was no one overseeing operations and staff performance to ensure systems were in place to prevent the development of pressure injuries, to ensure staff was consulting promptly with the physician concerning significant changes in a resident's condition, or to ensure a CPR certified staff person was working on all shifts. Pressure Injuries: The NHA did not ensure systems were in place so that staff could comprehensively assess wounds, develop a care plan to direct staff on care and treatment to promote healing and prevent new Pressure Injuries (PIs) from developing, and perform treatments to the wounds as ordered by the Physician. This affected 1 of 1 residents reviewed, R4. R4 was admitted at risk for the development of pressure injury. The facility did not develop a care plan to address his risk factors. R4 developed pressure injuries that progressed to stage IV. The facility did not comprehensively assess the pressure injuries, did not consult the physician timely, and did not put appropriate measures in place to promote healing of the pressure injuries. R4's pressure injuries got infected, requiring R4 to be hospitalized with a stage IV pressure injury that required antibiotics and debridement. Facility failure to put measures in place to prevent the development of a pressure injury and to promote the healing of pressure injuries created a finding of immediate jeopardy. Cross reference F686. Notification of Changes: The facility did not consult 1 of 1 resident's (R4) physician timely when R4 developed pressure injuries. R4 developed pressure injuries to his right and left feet. R4's physician was not consulted when the pressure injuries were noted delaying treatment of the pressure injuries. CPR: The NHA did not ensure a system was in place to ensure there was someone working each shift who was certified in CPR (cardiopulmonary resuscitation), which had the potential to affect 8 of 26 residents (R1, R2, R4, R6, R8, R9, R13, and R15) who are full code. The facility was unable to show that any of the three facility nurses were CPR certified until later in the survey. At that time, there was no evidence NHA/RN A was CPR certified. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Starting on [DATE] at 6:00 PM, NHA A, who is also an RN (Registered Nurse,) worked as a floor nurse in the facility without leaving the building until [DATE] at 6:00 PM, for a total of 84 hours straight. NHA A also worked on [DATE] and [DATE] from 6:00 PM to 6:00 AM during the night shift and was the only nurse in the building. NHA A did not have current CPR certification. CNA/Main/Transp I (Certified Nursing Assistant/Maintenance/Transportation) was transporting residents to appointments without current and up to date CPR certification. The facility's failure to ensure a CPR certified staff was working in the facility at all times created a finding of immediate jeopardy that began on [DATE]. Cross reference F678. The facility's lack of administrative oversight resulted in high level citations that affected resident care. The facility lacked a full time DON which resulted in the NHA working as the DON and NHA. Due to a lack of sufficient nursing staff, the NHA was found to have worked over 84 hours in a row, and was found to be sleeping while on duty. The NHA was therefore unable to perform the duties that are required of an NHA.

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. 40590 Based on observation, interview, and record review, the facility Governing Body failed to implement policies related to the management and operation of the facility, and were not actively engaged and involved in the daily operations of the facility. The governing body knowingly failed to communicate with facility management with regard to operations of the facility. The governing body did not provide the support necessary to the management of the facility to ensure residents were cared for in a matter that maintained their well being which affected the quality of life of all 24 residents. The [NAME] President of Operations (VP) C was aware Registered Nurse (RN) F had restrictions on her license in March 2022 which required the RN F to have supervision while performing her duties. RN F was scheduled to work shifts alone and without the required supervision. The facility has had six Nursing Home Administrators and five Directors of Nursing (DON) over the past year. The facility did not have a DON of record from 07/28/22 - 08/04/22. The VP C was aware of the lack of sufficient staff and that the facility lacked a full time DON which resulted in the NHA working as the DON and NHA. Due to a lack of sufficient nursing staff, the NHA was found to have worked over 84 hours in a row, and was found to be sleeping while on duty. The NHA was therefore unable to perform the duties that are required of an NHA. The facility had multiple high-level citations due to lack of staffing and continued to run at less than defined staffing levels per the facility assessment. This is evidenced by: The policy and procedure titled, Administrative Management (Governing Board,) states, in part, The facility's governing board is the supreme authority and has full legal authority and responsibility for the management and operation of the facility. The Administrator is appointed by and accountable to the governing board, and The governing board is responsible for the establishment and ongoing review of all administrative programs governing facility management and operations. Example 1: No appointed Director of Nurses: On 08/04/22 and 08/05/22, during a complaint survey, the state survey agency noted the facility did not have a DON (Director of Nursing), was not providing supervision to a RN (registered nurse) who has license restrictions that included direct supervision, and that the NHA (Nursing Home Administrator) was working as many as 84 hours in a row without leaving the facility. The NHA was also noted to be sleeping in the therapy room at night during the 84 hours without relief. (continued on next page)

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	525678	A. Building B. Wing	08/16/2022

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 08/05/22 at 8:25 AM, NHA A showed Surveyor a copy of a text message received from the previous DON which states, I don't think I can work tonite [sic]. I'm not coming back. You're right. Too many lies. My health is more important right now. I have to take care of myself. You should do the same. They r [sic] going to close. My family is on my back to leave. So I am going to do what I need to do for me. I can't risk not walking because I'm pushed to work. The DON resigned from the facility on 07/28/22 effective immediately. The facility has not had an acting DON since 07/28/22. On 08/04/22 at 5:40 AM, Surveyor interviewed NHA/RN A. Surveyor asked NHA/RN A if they had appointed anyone to be the interim DON. NHA/RN A stated, We have not appointed anyone at this time, no one wants to do it. RN F would do it but is unable to do so as she has restrictions on her license. Example 2: Allowing a nurse with a restricted license to work unsupervised: RN F requires direct supervision while working in accordance with her license restrictions. It was determined that this RN worked the following dates without the supervision her license requires: 07/02/22, 07/03/22, 07/04/22, 07/09/22, 07/10/22, 07/23/22, 07/24/22, 08/06/22, and 08/07/22. On 08/04/22 at 7:50 AM, Surveyor interviewed RN F. RN F stated, There is always someone here acting as the charge nurse, NHA, DON, for RN K. If no one else is here, like on the weekend, I am the charge nurse. On 08/05/22 at 9:00 AM, Surveyor interviewed NHA/RN A. Surveyor asked NHA/RN A if she was aware RN F had restrictions on her RN license: NHA/RN A stated, The previous DON stated she needed to send in quarterly reports. That was all I knew. I have not read her restrictions. On 08/05/22 at 9:14 AM, Surveyor interviewed CHR L (Corporate Human Resources). Surveyor asked CHR L about RN F's license restrictions. CHR L stated, Our clinical team, including the DON and Corporate Team, reviewed RN F's restrictions. I knew she needed some type of supervision. VP C (Vice President) and NC D (Nurse Consultant) would have reviewed those restrictions. On 08/05/22 at 9:25 AM, Surveyor interviewed NC D. Surveyor asked NC D if he had reviewed RN F's RN license restrictions. NC D stated, I read the limitations on her license. I understood them as she had no limitations to practice but needed to be observed. Surveyor asked NC D when he was made aware of RN F's restrictions. NC D stated, I was made aware one week ago due to a discussion of making RN F the DON. During that discussion NHA/RN A indicated that RN F had a limited license. No one ever said she needed direct supervision. (continued on next page)

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 08/05/22 at 9:49 AM, Surveyor interviewed VP C. Surveyor asked VP C when he was made aware of RN F's license restrictions. VP C stated, I was made aware in March 2022 that she needed a licensed individual in the facility when she was working the medication cart. They wanted her to be the DON at one time and we discussed her restrictions then. Surveyor asked VP C if NHA/RN A was aware of RN F's license restrictions. VP C stated, I told the NHA that RN F needed to be supervised. NHA/RN A and I spoke and discussed it could be the NHA or someone in a supervisory capacity. We have had no issues with RN F. The DON walked out and the NHA and I discussed again the possibility of RN F taking over the DON role. Surveyor asked VP C about RN F's restrictions and if he was aware of the duration of those restrictions. RN F stated, The incident occurred in 2019 and signed in 2021. Surveyor asked VP C if he was aware RN F was working without supervision. VP C stated, I was aware she was working as the only nurse at times. We have had zero issues with her performance. We also felt that resident care was more important than supervision. I realize she should have been supervised. Example 3: Administrative turnover: The facility has had significant turnover in administrative staff. There have been 6 NHAs of record in the past year and five DON changes within the past year. The facility did not have a DON from 07/28/22 - 08/04/22. High turnover rate in the leadership role of Nursing Home Administrator makes it more difficult to provide sufficient and consistent support to residents and staff. In its QSO-22-08-NH memo, the Centers for Medicare & Medicaid Services (CMS) indicates Staffing in nursing homes has a substantial impact on the quality of care and outcomes residents experience. CMS has long identified staffing as a vital component of a nursing home's ability to provide quality care. Facilities with lower nurse turnover may have more staff that are familiar with each resident's condition and may be more able to identify a resident's change in condition sooner. The facility may be able to implement a plan to avoid an adverse event, such as a fall, for a patient. Lower administrator turnover may have a positive impact on leadership stability, direction, and operations, which may help staff provide more care consistently and effectively to residents. Example 4: Lack of sufficient staff: At the time of this complaint survey, the facility employed a total of 3 Nurses, one which has restrictions on her license that requires her to have direct supervision, second is the NHA who is also an RN, and the third is the staff development coordinator. NHA/RN A worked the following hours and was the only nurse on duty from 07/28/22 at 6:00 AM until 07/31/22 at 6:00 PM. (Note: NHA/RN A worked a total of 84 hours straight between 07/28/22 and 07/31/22.) NHA/RN A worked on 08/01/22 from 6:00 AM to 6:00 PM and 08/03/22 from 6:00 PM to 6:00 AM on 08/04/22 Note: NHA/RN A did not leave on 08/04/22 at 6:00 AM due to Surveyors being in the facility. NHA/RN A worked 08/04/22 from 6:00 PM to 11:30 AM on 08/05/22 (continued on next page)

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Note: NHA/RN A did not leave on 08/05/22 at 6:00 AM due to Surveyors being in the facility. RN F did not show up for her shift until 11:30 AM on 08/05/22. NHA/RN A worked a total of 17.5 hours without leaving the building between 08/03/22 and 08/05/22. On 08/05/22 at 7:10 AM, Surveyor spoke with NHA/RN A. Surveyor asked NHA/RN A if she had left on 08/04/22 after Surveyors left the building. NHA/RN A stated, No, I ended up staying through the night shift as there was no one to relieve me. I only got about an hour of sleep. When NHA/RN A worked as a floor nurse, there was no one functioning as the facility's administrator. Example 5: Multiple repeated citations: The facility continues to receive repeated citations for quality of care and staffing deficiencies, many of which have been at the harm (G) or immediate jeopardy (J, K, L) level. Repeated citations include: F678-K on 08/16/22. F684-G on 07/14/21, F684-G on 12/20/21, F684-G on 03/09/22, and F684-G 05/10/22. F686-D on 06/14/21, F686-E on 07/14/21, F686-D on 03/09/22, F686-J on 05/10/22, F686-D on 07/27/22 and F686-J on 08/16/22. F689-G on 06/14/21, F689-E on 07/14/21, F689-G on 03/09/22, F689-J on 05/10/22, F689-G on 06/01/22 and F689-D on 06/09/22. F700-J on 05/10/22 and F725-E on 07/27/22. F725-G on 06/14/21, F725-L on 07/14/21, F725-F on 03/09/22, F725-F on 05/10/22, F725-F on 06/09/22, F725-F on 07/27/22 and F725-L on 08/16/22. F727-F on 06/09/22 and on 08/16/22.

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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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 41994 Based on interview and record review, the facility did not identify issues to which quality assessment and assurance activities are necessary or develop and implement appropriate plans of action to correct identified quality deficiencies. The was evidenced by the number and seriousness of citations at this current survey, and repeated high-level citations over the past year. This had the potential to affect all 26 residents in the facility. This is evidenced by the following: The policy titled, Quality Assurance & Performance Improvement (QAPI,) was reviewed. The policy stated, in part, .QAPI Mission The facility will maintain an ongoing, facility-wide QAPI Plan designed to monitor and evaluate the quality and safety of resident care, pursue methods to improve care quality, and resolve identified problems .The administrator is responsible for assuring that this facility's QAPI Program complies with federal, state and local regulatory agency requirements . The policy titled, Governing Body Policy and Procedure, was reviewed. The policy stated, in part, .The Governing Body should foster a culture where QAPI is a priority by ensuring that policies are developed to sustain QAPI despite changes in personnel and turnover. Their responsibilities include, setting expectations around safety, quality, rights, choice and respect by balancing safety with resident-centered rights and choice. The governing body ensures staff accountability, while creating an atmosphere where staff is comfortable identifying and reporting quality problems as well as opportunities for improvement .It is the policy and procedure of Minocqua Health and Rehabilitation to appoint the administrator as the quality assurance and performance committee chair QAPI . During this complaint and extended survey, from 08/04/22 through 08/16/22, there were three high level citations, F678 at a K, F686 at a J, and F725 at an L (all at the level of immediate jeopardy). The facility also received five additional citations, including: F580, F727, F835, F837, and F867. Over the past year, the facility received the following, repeated citations (Citations at J, K, or L are at the level of immediate jeopardy; citations at a G level are actual harm; citations at D, E, or F are at a level of potential for more than minimal harm.) F684 (quality of care)-G on 07/14/21, F684-G on 12/20/21, F684-G on 03/09/22, and F684-G on 05/10/22. F686 (prevention of pressure injuries)-D on 06/14/21, F686-E on 07/14/21, F686-D on 03/09/22, and F686-J on 05/10/22 and on current survey. F689 (accident prevention)-G on 06/14/21, F689-E on 07/14/21, F689-G on 03/09/22, and F689-J on 05/10/22. F725 (staffing)-G on 06/14/21, F725-L on 07/14/21, F725-F on 03/09/22, and F725-F on 05/10/22, and an F725 at an L on current survey. (continued on next page)

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	08/16/2022

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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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility has had five different administrators in the past 12 months. A new DON started on 08/15/22 as the facility had been without a DON since 07/28/22. On 08/16/22, Surveyor reviewed the QAPI binder. There were sign in sheets indicating QAPI meetings, however there were no PIPs (Process Improvement Plans) present. On 08/16/22, Surveyor interviewed NHA regarding the QAPI process. Surveyor asked what tool was being used to develop changes in processes. NHA stated that they were using past POCs (Plans of Correction) as the PIPs. Surveyor inquired as to what changes had been made to the process as the current high-level citations indicated the process was not working. The NHA stated that they felt that since there were mostly new employees present now than there were at the time of the previous citations that the process was working. The facility Quality Assurance Committee has failed to identify key areas of deficient practice and implement action plans to correct these deficient practices.