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	06/14/2021

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17661 Based on observations, interviews, and record reviews, the facility did not consistently care for 3 out of 14 residents (R2, R18, R21) in a dignified manner, recognizing their individuality and promoting enhancement of his/her quality of life. - Resident (R)18 stated he laid in diarrhea in bed for over 1 hour 10 minutes before staff responded to his call light. - R21 stated she laid in a soiled brief for over two hours before staff were able to respond to her call light. - R2 expressed feelings of humiliation when having to wait greater than one hour in a brief that was soiled with bowel movement This is evidenced by: The facility policy and procedure for Dignity was reviewed. According to the policy statement, Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. The policy continues to state, the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth and demeaning practices and standards of care that compromise dignity are prohibited. Example 1: R18 has medical diagnoses that include, but are not limited to, Nondisplaced Fracture of the Greater Trochanter, Pressure Injury (PI) Left Heel-Stage III, Pressure Injury (PI) Right Buttock Unstageable with a wound vacuum, Morbid Obesity, Low Back Pain, Presence of Intrathecal pain pump, Major Depressive Disorder, Anxiety Disorder, Ataxia, Venous Insufficiency, Polyosteoarthritis, Presence of Left Artificial Hip Joint, Presence of Bilateral Artificial Knee Joint, and Anemia. According to the Minimum Data Set Assessment (MDS) completed for R18, which was an admission assessment dated [DATE], R18 has a Brief Interview of Mental Status (BIMS) score of 13/15, indicating slight areas of confusion but overall, cognitively intact. Other areas assessed include: (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- R18 requires extensive assistance of two staff to meet his most basic daily tasks of bed mobility, transfers, and toilet use. He is non-ambulatory related to a recent hip fracture and the inability to apply direct pressure on his right leg, as well as a Stage III PI to his left heel that was recently skin grafted, thus is transferred with the use of a mechanical lift. He requires extensive assistance of one staff to meet his most basic needs of dressing and personal hygiene, and is dependent on staff for bathing. This MDSA also assessed R18 as being occasionally incontinent of bladder function and always incontinent of bowel function. R18 has a history of depression and takes Bupropion (150 Milligrams daily), an antidepressant used to treat major depressive disorder and seasonal affective disorder. During the screening process of R18, on 06/08/21 at 11:03 AM, the Surveyor asked him if he receives care and his needs are met in a timely manner. R18 frowned and stated, There is a terrible, terrible staffing problem here. I am supposed to get the dressing on my foot (sticks out his left leg) every morning. Yesterday, they didn't come and they didn't come. Finally at 7:00 last night I asked 'when is my dressing going to get replaced?' The nurse on the evening shift finally did it. I have to direct all my own care or I wouldn't get taken care of the way I am supposed to. They don't either follow the orders the doctor has written, or they have no time to read them. Last night, I put on my call light a little after 7:00, after the nurse did my treatment. I had to go diarrhea. When I need to go, I need to go NOW. I tried to hold it, but finally it flowed like the Niagara falls out of me. That was after 1 hour and 10 minutes of waiting for someone to answer my call light. If you don't think that was embarrassing. Just terrible to s--- (expletive) your pants and have to lay in it until some young chickie comes and has to clean you up. Horrible! I am a grown man, and let me tell you, taking a dump in your pants is a most horrific feeling . right now, I am paying for the full load. I just wrote them out a check .the other day. I don't mind paying for it, but the expectation is that with that amount of money, I damn well better get better care than I am at this point. I will pay whatever is needed, but I expect better service than laying in s--- (expletive) for over an hour! Example 2: R21 has medical diagnoses that include but are not limited to Malignant Neoplasm of the Vulva and Thyroid Gland, Weakness, History of Falls, Functional Urinary Incontinence, and Urge incontinence. According to the most recent Minimum Data Set Assessment (MDSA) completed for R21, which was a Significant Change in Status assessment dated [DATE] related to R21 enrolling in Hospice Services, R21 requires extensive assistance of two staff to meet her most basic daily tasks of bed mobility, dressing, and toilet use. She requires extensive assistance of one staff to meet tasks such as transfers and personal hygiene. She is non-ambulatory and frequently incontinent of bowel and bladder function. The facility conducted a Brief Interview of Mental Status (BIMS), which scores the individual's cognitive function, and scored R21 as 9/15, indicating moderate impairment. The facility also conducted a PHQ-9 (Patient Health Questionnaire) which assesses each of the 9 DSM-IV (Diagnostic and Statistical Manual of Mental Disorder) criteria. R21 scored 8/27, which indicates mild depression. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the screening process on 6/8/21 at 10:27 AM, the Surveyor asked R21 if she receives care and her needs are met in a timely manner. R21 shook her head and stated, I feel they really need help badly. There are times I do have to wait upwards of two hours for help. Once I laid in my soiled diaper in bed for over two hours with my call light on. I soiled several times in that same incontinent product before someone came to help me. I think I would have been able to go on the toilet had someone come in when I put on my call light. Sometimes it is frustrating. That was very embarrassing for me, having to have young girls clean up a soiled diaper of an old lady. They are short staffed like everyone else in this country right now, people don't want to work . Sometimes the girls get short with us and say they can't help that they can't provide better service because they are short staffed, and will get grumpy. I just tell them, 'Well, I am not receiving the services I would want either' we're all in the same boat. I have to wait until they help me. They don't let me get out of my wheelchair by myself, but yet, they don't walk me in the hall either, so that I can get stronger. They don't have enough staff to do that, so I sit here, all day, just waiting. I guess I could put on my call light and ask for help, but I feel so bad for them. They just don't have the time . On 6/10/21 at 1:18 PM, the Surveyor interviewed Certified Nursing Assistant (CNA) P regarding general staffing and services provided to residents. CNA P stated she felt concerned because she is unable to provide residents with care they are deserving of. CNA P stated, It takes a long time sometimes to answer their call lights because we are short staffed and if we are in a room taking care of someone, we cannot leave to answer call lights. So sometimes it can be one-half to one hour, sometimes longer if there are several call lights going off at one time. I feel terrible for them (residents), they deserve better care. Some nurses will help out, but others won't. We don't have all people that work here help with call lights, which is frustrating when you see people just walk past them. CNA P was asked if she had noticed some decline in residents as a result of not being able to assist them timely. CNA P stated, Oh yes, there is an increase with incontinence because we can't get them to the bathroom in time, so they have to wait for us and end up going in their pants or in bed. I apologize to them, but I know it is embarrassing for some of the residents . I just wish we could give them better care but we are so strapped and can only do so much . 30570 Example #3: On 06/08/21 at 1:50 p.m. the surveyor spoke with R2. R2 indicated she is blind and bed ridden for the most part. R2 further expressed it takes staff a long time to respond to her call light. Usually greater than a half hour and greater than 1 hour is common. R2 expressed she puts on her light due when she needs to be changed. R2 further expressed it is humiliating to lay in bed full of (*X*X-expletive)- bowel movement for over an hour waiting for staff to answer her call light and change her. R2 indicated most staff change her when they get there but often has to wait for someone else after her light is answered. Often having to wait a long time to be cleaned up. Staff say they are too busy to respond to call lights because there is not enough help. R2 further indicated there are a lot of nurses but the facility need aides. Some nurses help, but not all. Some will not help out when you ask. Waiting over an hour full of (*X*X-expletive) bowel movement and you can't help yourself is humiliating. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The surveyor reviewed R2's most recent Minimum data set completed 5/19/21 and noted the following: R2 understands, is understood, and is cognitively intact. R2 is always incontinent of bowel movement and is dependent on staff for personal hygiene. The surveyor reviewed R2's care plan and noted the following: Focus: ADL (Activities of Daily Living) deficit . Goal: Will have all ADL needs met by staff Toileting: incontinent of bowel, approximately change every 2 hours and prn (as needed). On 06/09/21 at 9:52 a.m. the surveyor spoke with Certified Nursing Assistant (CNA) M. CNA M expressed the facility is currently scheduling 3 nurse aides on am and pm shift for 4 floors and 50+ residents. CNA M further expressed it is impossible to respond to call lights timely when the CNA is pulled off one floor to assist on another floor. Often the CNA is absent from the floor for long period of time which causes long wait times for residents to have their needs met. The surveyor asked CNA M if residents are having to wait one hour or greater. CNA M responded she has heard residents complain that they have had to wait over an hour. 22548

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F 0607 Level of Harm - Potential for minimal harm Residents Affected - Many	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 17661 Based on interviews and record reviews, the facility failed to ensure that it did not employ individuals who were found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment, by failing to conduct comprehensive criminal background checks for 5 of 8 staff members reviewed for the Caregiver Program Compliance Review. This has the potential to affect all 54 residents. A complete Criminal Background Check includes obtaining an individual's criminal history from the following sources: - Wisconsin Department of Justice (DOJ); - Background Information Disclosure (BID); and - Integrated Background Information System Letter, a Department of Health Service's letter that details an individual's offensive history. A denial or revocation identified on the IBIS letter means the individual committed an offense that created a bar to regulatory approval, household member residency, or employment. The comprehensive criminal background check is to be completed upon hiring all new employees, as well as every four years thereafter. The facility did not complete comprehensive Criminal Background Checks (CBC) on the following: 1. Certified Nursing Assistant (CNA) Q 2. CNA R 3. Cook H 4. Maintenance S 5. Activities T This is evidenced by: The facility policy on Abuse dated 10/15/2017 indicates under Screening of new Employees: This facility will not employ individuals who have abused, neglected, exploited or Misappropriated funds . will not employ or otherwise engage individuals who: (a) Have been found guilty of abuse, neglect, exploitation, misappropriation of property or treatment by a court of law; (continued on next page)

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F 0607 Level of Harm - Potential for minimal harm Residents Affected - Many	(b) Have had a finding entered in the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment or misappropriation of their property; or (c) have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment or residents or misappropriation of resident property. This facility will not hire or maintain in its employ any direct health care provider without proper verification from professional registries as applicable, previous employers and state policy agency as follows .C. All potential employees will submit to a criminal conviction history check done through the Wisconsin State Police Department, and other sources as applicable, prior to being employed and every 4 years if employed. This facility will not employ anyone with any criminal conviction history that the facility deems as being unacceptable behavior for someone working within a healthcare facility which will include but not limited to any legal convictions of theft, fraud, and/or violence against others and verify that the applicant is not excluded from any Federally-funded health care programs . On 6/10/21 at 9:40 AM, the Surveyor conducted the Caregiver Program Compliance Check as part of all annual nursing home Recertification surveys. A random sample of employees from various departments was chosen to review for a criminal background history. During this review, the Surveyor noted missing critical background check information on the following five employees: 1. CNA Q, original hire date - 05-24-2006, was missing a DOJ review and IBIS letter; 2. CNA R, original hire date - 10-01-2019, was missing a DOJ review and IBIS letter; 3. Cook H, original hire date - 05-20-2013, was missing a current BID, a current DOJ review, and a current IBIS letter. The last was completed 4/25/17 and DOJ/IBIS was 4/26/17; 4. Maintenance S, original hire date - 10-21-2019, did not have a DOJ review or IBIS completed; and 5. Activities T, original hire date - 09-08-2020, had no DOJ review or IBIS completed. On 10/1/20, the facility was taken over by a new company. Several previous staff were then rehired with this hire date. On 6/10/21 at 10:25 AM, the Surveyor interviewed Staff C (Human Resources Director) regarding criminal background checks. According to Staff C, who first became employed by the facility 12/28/20, the former owner of the facility kept all criminal background records and would not release them. The Human Resources person at the time (no longer with the facility) was to re-run background checks upon the new company ownership, but Staff C was unable to find evidence that she did. (continued on next page)

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F 0607 Level of Harm - Potential for minimal harm Residents Affected - Many	Staff C supplied surveyor with an Electronic-Mail (E-Mail) print out, dated this date (6/10/21) to the new company Human Resources in which the question was posed whether employee background checks were conducted with the change in ownership. The Human Resource (HR) person sent the question on to the company Chief People Officer who replied that background checks were not re-run and the previous HR individual was responsible to complete audits on all staff that did not have current background check records in their file. There was no evidence uncovered to ensure these missing checks were conducted.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 30570 Based on observation, record review, and interview the facility did not provide the needed Activities of Daily Living (ADL) cares for 1 of 4 residents, (R2,) reviewed for cares. R2 does not receive a weekly bed bath as indicated in her plan of care. R2 is not provided the needed supplies and assistance by staff for brushing her teeth on a daily basis. This is evidenced by: On 06/08/21 at 1:34 pm the surveyor spoke with R2. R2 indicated she is supposed to get a full bed bath every Friday morning, but does not. R2 further expressed she gets a bed bath every couple of weeks. R2 further expressed she is unable to get supplies and complete the bed bath on her own. She is blind and bed ridden for the most part. R2 further expressed staff change her in the morning and evening but most often do not wash her up. The bed bath is needed each week to feel clean. On 06/09/21 at 10:07 am the surveyor spoke with Certified Nursing Assistant (CNA) M regarding R2's cares. CNA M indicated she is familiar with R2. CNA M expressed she completes R2's bed bath on Friday morning when she is assigned the 100 unit. CNA M further expressed CNAs are often unable to complete thorough cares; including bed baths due to being rushed to complete cares for too many residents. The facility is currently staffing 3 CNAs for 4 units of 50+ residents. Staff try their best but can not get everything done as thorough as it should for the residents. CNA M expressed she records the bed bath was done on R2's bed bath sheet in the computer and notifies the nurse when it is completed. 6/09/21 at 2:45 p.m. the surveyor requested and received R2's data for bed baths since 1/01/21. The data notes the following: Bathing weekly Friday AM and PRN (as needed)/bed bath: January 2021: 1/01/21, 1/26/21 (25 days from previous bed bath) and 1/29/21-noted 4/2= dependent on 1 staff for bed bath. February, 2021: 2/12/21 (15 days from previous bed bath) and 2/26/21 (14 days from previous bed bath)-noted as 4/2=dependent on 1 staff for bed bath March, 2021: 3/05/21, 3/12/21, 3/19/21, 3/26/21-noted as 0=Independent-no help or staff oversight at any time April, 2021: 4/2/21, 4/09/21, 4/16/21, 4/23/21 and 4/30/21 noted as 0=Independent or no staff help or oversight at any time May, 2021: 5/07/21, 5/14/21, 5/21/21 and 5/28/21: 4/2=dependent on one staff for bed bath June, 2021: 6/04/21: 0=Independent or no staff help or oversight at any time (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/09/21 at 2:45 p.m. the surveyor spoke with Registered Nurse (RN)/Minimum Data Set Coordinator K regarding R2's frequency of receiving a bed bath and bath documentation. RN K indicated prior to March, 2021, R2 was not scheduled on any specific day to receive a bed bath. The bed bath was a PRN (as needed). The facility scheduled R2 on Friday AMs in March. The facility could not tell when R2 was receiving a bed bath due to lack of documentation. Starting in March the data reflects a 0 which indicates R2 gave herself a bed bath with no help from staff. RN K further stated R2 is unable to give herself a bed bath and is dependent on staff as noted as a 4/2. The 0=data indicates no staff help and does not show R2 received a bed bath. On 6/08/21 at 1:34 p.m. R2 told the surveyor her teeth are not brushed by staff each day. R2 expressed she depends on staff to provide her with toothbrush with paste for her to brush teeth. Staff need to help her brush her teeth as she is blind and not sure she is doing a good job. Need staff to provide cup of water to rinse mouth and basin to spit. She can not get up on own to get supplies, can not fill a glass with water and can not do a thorough job brushing teeth. Further expressing she needs staff to help and has lost teeth in the past due to poor hygiene. R2 further expressed she is provided supplies and assisted with brushing her teeth about one time a month for the past year. R2 expressed her teeth feel grimy and she has resorted to cleaning her teeth by picking at them with her fingernails and wiping her teeth with a Kleenex. R2 further expressed she has had 4 teeth removed since living at the facility about a year ago due to poor oral hygiene. On 06/09/21 at 10:02 a.m. the surveyor again spoke with R2. R2 informed the surveyor she had been washed up in bed after breakfast, her gown and brief were changed and her hair was combed this morning. R2 expressed her teeth were not brushed again. R2 indicated she has 9 teeth remaining on the bottom and 3 teeth on top and does not want to loose any more teeth. Staff did not brush her teeth this morning and rarely do. R2 further indicated she will need to clean her teeth with fingernails and Kleenex which is not sufficient to get them clean. R2 again indicated she has had teeth extracted in the past because of poor care of her teeth and it was not done again today. During the conversation the surveyor noted a small basin on R2's bedside dresser containing a toothbrush which was visibly dry. On 06/09/21 at 10:07 am the surveyor spoke with Certified Nursing Assistant (CNA) M regarding R2's oral care. CNA M indicated she is familiar with R2. CNA M expressed R2 has some teeth. R2 needs staff to gather supplies, fill cup with water, and assist with brushing her teeth to do a thorough job. CNA M expressed she had completed R2's cares this morning with the exception of brushing her teeth. CNA M further expressed R2's teeth should be brushed 1x a shift. CNA M indicated resident toothbrushing is often one of the things the aides do not have time to do because of rushing with cares and lack of staffing. R2 is unable to gather her supplies as she can not get up on her own, she is unable to fill a glass of water on her own and is unable to thoroughly brush her teeth on her own. R2's most recent annual Minimum Data Set (MDS) completed on 5/19/21 notes: ~Understands, is understood and is cognitively intact. ~Does not reject cares, does not transfer from bed and requires extensive assistance of one staff for personal hygiene (including brushing teeth and washing self). Previous quarterly MDS noted on 2/17/21: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	~Understands, is understood and is cognitively intact. ~Dependent on staff for transfer and personal hygiene (including brushing teeth and washing self). R2's Care plan notes: Focus: ADL (Activities of Daily Living) self-care deficit related to Diabetes Mellitus, glaucoma, blindness, foley catheter, depression, anxiety, weakness and impaired mobility, personal Goal: R2 will have all ADL's met by staff through review date. Date initiated: 1/18/21, revised on 6/04/21 with a target date of 9/04/21 Interventions: Bath Day: Extensive assist on Friday a.m. and prn Morning/bedtime cares: extensive assist of 1 for upper, dependent for lower and bed bath Oral Care: has own teeth, can brush own teeth with set up. The surveyor requested ADL documentation for R2 including oral care since 01/01/21. Review of the data shows no area for staff to record oral cares as completed. On 06/14/21 at 1:45 p.m. the surveyor spoke with Director of Nursing (DON) B regarding R2's care and staffing to meet resident needs. DON B expressed R2 is dependent on staff to meet her needs. She is alert and oriented. She can not complete her care on her own and she would expect staff to provide the needed care and assistance as outlined in R2's care plan. DON B further expressed the facility does not have enough staff to meet the needs of the residents, cares are rushed, things are missed, and short cuts are made due to current staffing levels.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17661 Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 3 residents (R21) reviewed for Pressure Injuries, received care consistent with professional standards of practice and based on a comprehensive assessment to prevent pressure Injuries (PI) from developing. R21 is a high risk for the development of PIs. She is to be repositioned every two hours. An observation was made on 6/9/21 in which this was not completed by staff for a time period of 3 hours 42 minutes. This is evidenced by: R21 was admitted to the facility 3/26/21 with medical diagnoses that include but are not limited to, Malignant Neoplasm of the Vulva and Thyroid Gland, Weakness, History of Falls, Functional and Urge Urinary Incontinence, Paraneoplastic Neuromyopathy and Neuropathy, Hypokalemia, Hypomagnesemia, Adult Failure to Thrive, Severe Protein-Calorie Malnutrition, and Iron Deficiency Anemia. According to the most recent Minimum Data Set Assessment (MDS) completed for R21, which was a Significant Change in Status assessment dated [DATE] related to R21 enrolling in Hospice Services, R21 requires extensive assistance of two staff to meet her most basic daily tasks of bed mobility, dressing and toilet use. She requires extensive assistance of one staff to meet tasks such as transfers and personal hygiene. She is non-ambulatory and frequently incontinent of bowel and bladder function. The facility conducted a Brief Interview of Mental Status (BIMS), which scores the individual's cognitive function, and scored R21 as 9/15, indicating moderate impairment. The Surveyor conducted a brief record review of R21 and noted the following Care Plans (CP) included in R21's plan of care (POC), 3/27/21: 1. The resident has potential for pressure ulcer development and/or impaired skin integrity r/t (related to) non-ambulatory, incontinent, malignant neoplasm of vulva and thyroid: cancer lesions, opioid med use, refusals to reposition The goal set by the facility for R21 was that R21 will have intact skin, free of redness, blisters or discoloration by/through review date Included in the interventions for this POC is to reposition resident every two hours. 2. The resident has actual impairment to skin integrity of the right and left buttock, cancer lesion to vulva r/t incontinence, malignant neoplasm of vulva Goal: The resident will have no complications r/t Incontinent Associated Dermatitis (IAD) of the right and left buttock and cancer lesions to the vulva through the review date Included in the interventions for this POC Keep skin clean and dry. (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	06/14/2021

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 - Minimal harm or potential for actual harm Residents Affected - Few	Note: The area of breakdown in which R21 was admitted has since healed. 3. The resident is risk for falls r/t non-ambulatory, incontinence, malignant neoplasm of vulva and thyroid: cancer lesions, pain, opioid med use, antianxiety med use: anxiety/terminal restlessness, hospice care, anemia, confusion/delirium Included in the interventions for this plan of care is Check and change every 2 hours and prn (as needed). 4. The resident has an ADL self-care performance deficit r/t cancer, hospice Goal: R21 will have all ADL's and wants/needs met by staff assistance through the review date Included in the interventions for this plan of care are for staff to Toilet use: max assist, incontinent of bowel and bladder. Check and change approximately q2hr (every two hours) and prn. Use peri wash bottles for comfort with cleansing. Chucks underneath while in bed. The Surveyor conducted a continuous observation on 6/9/21 beginning at 9:45 AM. This was as follows: - At 9:45 AM, R21 returned to her room after receiving a Covid-19 shot. She was brought to her room in her wheelchair. R21 sat watching television. At 10:06 AM, she fell asleep with her head falling down, chin to chest. Between 9:45 AM- 11:28 AM, no staff entered R21's room to provide care, inquire if she needed any services such as toileting, attempted to reposition or toilet her, or offer to lay down for a nap. - At 11:28 AM Registered Nurse(RN) U entered R21's room to administer medications. There were no offers for toileting or repositioning at this time. - At 11:29 AM: Hospitality Aide V entered R21's room to check supplies. - At 11:34 AM Housekeeping entered R21's room and changed the garbage bag in the trash can. - At 11:35 AM, a visitor arrived and sat down to chat with R21. The Surveyor entered the room and learned the visitor was a former neighbor of R21's. - At 11:50 AM, the visitor took R21 outside in her wheelchair for a quick walk around before meal service. R21 stated that she will return very shortly I just want to feel the warm sun. - At 12:10 PM, R21 returned with her visitor to her room. - At 12:13 PM, R21 was served her noon meal of a pork sandwich, pasta salad and green beans with vanilla pudding and two 8 oz glasses of apple juice; - At 12:50 PM Hospitality Aide V returned to R21's room to remove the meal tray. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- At 12:57 PM, RN U re-entered R21's room to question her on symptoms she may be feeling after the Covid shot she received earlier in the day. RN U then left the room without any offers for repositioning, toileting, or assisting her to lay down. - At 1:06 PM, R21's visitor left. No staff entered to offer or assist R21 with toileting or repositioning. - At 1:27 PM CNA W entered R21's room and offered to assist her to the bed. CNA W placed a gait belt around R21's waist and pivot-transferred R21 to her bed. This was a time frame of 3 hours, 42 minutes The resident was then asked by CNA W if she needed her brief changed. R21 acknowledged that she did by stating, Yes I do have something in there. CNA W removed the heavily saturated incontinent brief from R21. Her buttocks and perineum had no open areas but there was a small area of recently healed tissue on her left buttocks from a recently healed PI. Her buttocks and front perineum were dark red. CNA W then cleansed the resident and applied Calmospetine with Honey to her back perineum, washed her hands, and applied a clean brief. Surveyor then asked CNA W what the expectation of care is for R21. CNA W stated, We should do a toilet check and reposition every two hours, but lately she has been able to let us know when she needs to be changed. Part of the reason for today is because I am watching two wings, so things are a little behind. According to Wound Care Education Institute (WCEI), immobile or bed bound individuals require a full change in position that should be conducted a minimum of every two hours. Some individuals require more frequent repositioning due to their high risk status. Even though R21 does not currently have an active PI, she remains at risk related to her immobility, prior history of PIs and co-morbid conditions. This extended time period of no pressure redistribution as well as the urinary incontinence increased the potential for R21 to develop another PI.

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	525678	A. Building B. Wing	06/14/2021

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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** 22548 Based on observations, interviews, and record reviews, the facility failed to implement new approaches with changes in the care plans (CP) in attempts to prevent additional falls from occurring for 2 out of 5 residents (R) reviewed for falls (R11 and R33). The facility failed to do a root cause analysis of the falls, conduct a complete investigation of the falls, or do a risk assessment to identify potential for additional falls. - R33 had a fall in January 2021 after she attempted to transfer self onto the toilet. There was no investigation into the root cause of the fall and no care plan interventions implemented following this fall. R33 made another similar self transfer attempt onto the toilet in April 2021. R33 sustained a left hip fracture and T11-T12 vertebral (spine) fractures. R33 was hospitalized to treat the hip fracture and manage the pain associated with multiple fractures. R33 returned to the facility under Hospice services. R33's ADLs (activities of daily living) have declined and R33 experienced pain as a result of the fall. - R11 had a fall during evening hours. The facility did not determine a root cause analysis nor implement a new intervention after this fall. A few hours later R11 fell again and sent to the hospital where it was determined R11 had sustained multiple fractures. After returning to the facility R11 continued to experience falls during evening hours. The facility did not complete a root cause analysis of the falls, did not increase monitoring of R11 during the evening hours, nor implement new interventions. This is evidenced by: Example #1: R33 was admitted to the facility for long term care on 10/26/18 with the following, but not all inclusive, diagnoses: dementia, heart disease, stroke, depression, and kidney disease. R33 had an AHCPOA (activated health care power of attorney) effective April 2018. R33's AHCPOA was son and FM (Family Member)-F. The facility completed a quarterly MDS (Minimum Data Set) assessment for R33 on 02/02/21 with the following data noted: ~always able to make self understood and usually able to understand others. ~BIMS (brief interview for mental status) was an 8 out of 15 indicative of moderate cognitive deficits. ~able to locomote in room and outside of room with supervision. ~frequently incontinent of bladder and bowel. ~had no pain. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	~weight was 141#. The facility completed a significant change in status MDS assessment for R33 on 05/03/21 and noted the following declines: ~decline in ability to make self understood. ~decline in BIMS or cognitive function to 5 out of 15. ~change in bladder function. R33 had an indwelling catheter placed. ~decline in transfers. R33 was bedrest and did not transfer. ~decline in ability to locomote in room and outside of room. R33 was bedrest and did not locomote. ~decline in weight to 130#. ~reported frequent moderate pain that affected sleep and day to day activities. Review of the care plan titled .ADL self care . initiated 01/14/21 and last revised on 04/27/21 included fall interventions that read Fall Risk: bed in low position, anti rollback device on w/c (wheelchair), bilateral grab bars ., dycem under w/c seat, floor matt on side of bed, left side of bed against wall, call light in reach, pressure alarm to bed . Review of the care plan titled .risk for falls r/t (related to) confusion, incontinence, unaware of safety needs, decreased vision, Alzheimer's, diuretic (water pill) use, hx (history of) falls . initiated on 01/14/21 and last revised on 05/10/21 included interventions such as anticipate and meet needs, check on resident every 1-2 hours and provide repositioning, and review information on past falls and attempt to determine cause of falls, record root cause of falls, and remove potential causes. Review of R33's progress notes indicated on 01/04/21 at approximately 11:45 a.m., R33 was found on the bathroom floor. According to the nurses notes, R33 needed to go to the bathroom and had not put on call light. R33 did not sustain any injuries. The fall incident report noted R33 was confused, had impaired gait/balance, and memory. The incident report and progress notes did not indicate any changes to the care plan. Surveyor was unable to locate any change to the care plan or the identified root cause. On 01/04/21 at 3:32 p.m., the previous DON (Director of Nurses) documented in R33's progress notes that R33 was reaching for something on the floor which caused the fall to the floor. The facility gave R33 a reacher. The fall investigation did not include the last time a staff member provided care to R33 or did not include any investigation into the root cause of R33's fall. There was no information to support the previous DON's action to provide R33 with a reacher as that was not included in the investigation or identified as the root cause of the fall. The facility did not update the care plan to include the reacher. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of R33's progress notes indicated on 04/11/21 at approximately 7:30 to 8:00 p.m. R33 was heard yelling for help by an adjacent resident (R16). R16 put on her call light to summon staff to help R33. RN-E, CNA-D, CNA-L, and RN-BB responded to R33's calls for help and found R33 laying on her left side with her head against the wall in the bathroom. R33 complained of pain in her left leg, left shoulder, and back with movement. R33 had a fall and sustained a left hip fracture, T11-T12 vertebral (spine) fractures, and was hospitalized to repair the left hip fracture and manage the pain associated with the multiple fractures. R33 was readmitted to the facility on [DATE] under Hospice services due to poor prognosis following the fall. Review of the fall incident report noted R33's fall factors were incontinence, impaired memory, and weakness. There was no investigation into the root cause of the fall. There were no staff interviews when R33 had last received staff assistance with cares. The facility completed an admission pain assessment on 04/20/21 and noted R33 had moderate pain as evidenced by her statements, moaning, and crying out in pain with movement. In addition, R33 was placed on bedrest and an indwelling foley catheter was placed due to pain with movement. On 06/09/21 and 06/10/21, Surveyor requested any information regarding R33's falls that would identify a thorough investigation into the root cause of the fall and any changes to the care plan. On 06/14/21 at 10:50 a.m., DON-B stated there was no additional information on R33's falls in January or April of 2021. DON-B stated the root causes of R33's falls were not identified and there were no changes to the care plan made following R33's falls in January and April 2021. DON-B stated there were no investigations of R33's falls documented. On 06/14/21 at 11:05 a.m., ADON (Assistant Director of Nurses)-CC approached Surveyor and stated there was no additional information to provide regarding R33's falls in January and April, 2021. ADON-CC stated there was no investigation, no root cause analysis, and no changes to the care plan following R33's falls. Surveyor requested a list of all staff working on 04/11/21 on the second shift and noted there was two RNs (Registered Nurses) and two CNAs (Certified Nursing Assistants) for a census of 51 residents. During the survey, all four staff working on 04/11/21 were interviewed regarding the events surrounding R33's fall. All four staff reported inability to meet R33's needs due to short staffing as the cause of R33's fall and injuries. CNA-L, RN-BB, RN-E, and CNA-D reported R33 had been sitting in wheelchair since prior to supper and was likely tired and wanted to use the toilet then go to bed. RN-BB, CNA-L, RN-E, and CNA-D stated R33 was inconsistent when asking staff for assistance with toilet use. RN-BB, CNA-L, RN-E, and CNA-D also stated R33 was usually in bed between 7:00 and 7:30 p.m. (continued on next page)

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	525678	A. Building B. Wing	06/14/2021

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 06/09/21 at 3:00 p.m., Surveyor interviewed RN-E regarding R33's care needs and fall. RN-E confirmed she was on duty on 04/11/21 and assisted R33 following the fall. RN-E stated R33 had been sitting in the wheelchair for several hours and likely attempted to toilet self and fell . RN-E stated R33 was usually in bed around 7:00 p.m. RN-E stated usual staffing pattern for the second shift was 2 nurses and 2 CNAs (Certified Nursing Assistant) for an average census of 50 or more. RN-E stated all staff try to provide good care, but residents have to wait for call light response, help with toileting, and help getting ready for bed. RN-E stated all staff are frustrated because there isn't enough help and the facility continues to take new admissions. RN-E stated staff try hard to get the work done, but just can't when there are only 2 CNAs. RN-E stated showers, oral hygiene, toileting, and repositioning are not getting done because of not enough staff. On 06/9/21 at 7:15 p.m., Surveyor interviewed CNA-D who confirmed she worked on 04/11/21. CNA-D stated she had not provided any care for R33 since she arrived at the facility around 6:00 p.m. CNA-D stated there were only 2 CNAs on for the second shift on 04/11/21. CNA-D stated insufficient staffing was a factor in R33's fall because staff could not help her to the toilet after supper and R33 likely attempted to toilet self and fell . On 06/14/21 at 11:15 a.m., Surveyor interviewed CNA-L who confirmed he worked on 04/11/21. CNA-L stated R33 needed help with all ADL (activities of daily living) and was unsafe to transfer independently. CNA-L stated R33 had been up in the wheelchair since before supper and had likely wheeled self into the bathroom and attempted to toilet self and fell . CNA-L stated R33's usual bedtime routine was to use the toilet, wash up, brush her teeth, and settle into bed around 7:00 p.m. CNA-L stated the insufficient staffing was absolutely a factor in R33's fall. On 06/14/21 at 10:50 a.m. Surveyor interviewed DON (Director of Nurses)-B regarding the facility expectation following resident falls. DON-B stated the nurse at the time of the fall should conduct a thorough investigation of the cause of the fall. The investigation would include asking the resident what happened as well as interviewing the staff on duty. DON-B stated the nurse should attempt to determine the root cause of the fall and then implement appropriate care plan interventions based on the root cause. DON-B stated the IDT (interdisciplinary team) does meet to review the falls on the next business day and also to review the investigations completed at the time of the fall. The IDT looks for the root cause analysis identified. The IDT documents in the resident's progress notes that the fall was reviewed and reiterates the root cause as well as any changes to the care plan that were implemented. The IDT reviews the care plan and ensures that all changes were added and carried forward to be shared during the shift to shift report. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 6/14/21 at 4:00 p.m., Surveyor interviewed RN-BB via telephone regarding R33. RN-BB stated she was familiar with R33's care needs. RN-BB stated R33 required extensive to total staff assist for all ADL (Activities of Daily Living) needs. RN-BB stated R33 was able to make basic needs known and would sometimes use call light to ask for staff assistance, but was not consistent in the use of a call light. RN-BB stated R33 preferred to be assisted into bed before or near 7:00 p.m. RN-BB stated R33 had a fall on 04/11/21 when she attempted to toilet self. R33 was found in the bathroom on the floor. RN-BB stated she was called to assist RN-E, CNA-D, and CNA-L assess R33 following the fall. RN-BB stated R33 was unable to move without significant pain in her leg, back, and shoulder. RN-BB stated the contributing factors for R33's fall with injury and pain were R33's dementia and the lack of sufficient staffing in the building. RN-BB stated R33's fall was likely avoidable had staff assisted R33 with toileting and then into bed prior to 7:00 p.m. RN-BB stated R33 had likely been sitting in the wheelchair since before supper and was incontinent of urine and needing to be repositioned. RN-BB stated staff are unable to assist resident with repositioning and toileting needs timely. RN-BB stated the second shift was usually staffed with two nurses and one or two CNAs for an approximate census of 50 or more. RN-BB stated residents were not receiving adequate care with toileting, call light response, oral hygiene, skin care, and falls prevention because of the short staffing situation. On 06/09/21 at 8:30 p.m., Surveyor interviewed FM (Family Member)-F regarding the care of R33. FM-F stated R33 received marginal care at best and stated R33 has had several falls likely related to insufficient staffing. FM-F stated there was not enough staff to help R33 to the bathroom and due to R33's dementia, she does not know her transfer limits. 17661 Example #2: R11 has multiple medical diagnoses that include, but are not limited to Peripheral Vascular Disease (PVD), Spinal Stenosis of the Lumbar region, Major Depressive Disorder, Anxiety Disorder, Fibromyalgia, Osteoarthritis of the Knee and Right Wrist, Migraine Headaches, Cognitive Communication Deficit, History of Falls and Dementia. On 6/8/21 at 10:36 AM, the Surveyor conducted the screening process of R11 and noted a low bed with a concave mattress and a floor mat placed on the floor beside the right side of the bed with the left side of the bed against the window. R11 also had an alternating air mattress set at 15 with the firmness setting 5/8. The Surveyor completed a review of R11's Minimum Data Set Assessments (MDS's) and noted the following: 1. Quarterly MDS dated [DATE]: - Independent with bed mobility, transfers, ambulation both in her room and in the hall, locomotion on and off the unit, eating, toileting, personal hygiene and continent of bowel and bladder. - Supervision with no assistance from staff for dressing (continued on next page)

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	525678	A. Building B. Wing	06/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Actual harm Residents Affected - Few	2. Significant Change in Status MDS dated [DATE]: - Dependent on two staff for transfers - Dependent on one staff for bathing and locomotion on and off unit - Extensive assistance of two staff for bed mobility and toileting - Extensive assistance of one staff for dressing and personal hygiene - Indwelling urinary Foley catheter in place and always incontinent of bowel function - Non-ambulatory - Supervision of one staff for eating The following care plans (CP) were noted in R11's record: 1. CP plan: 1/16/20 start date: Last revised/reviewed 10/10/20: Problem: Resident is at risk for falls due to: psychotropic and opioid medications use, pain, spinal stenosis, fibromyalgia, low back pain, Osteoarthritis (OA), anxiety disorder Approaches: all dated 1/16/20 - 1:1 visit prn, assure comfort and dignity are maintained, invite family to care conferences. - Assure well light clutter free environment - Call light in reach in own room and bathroom, answer promptly, orient to to use and remind-especially at night - Comprehensive medication review by pharmacist, assess for polypharmacy and medications that increase the fall risk per policy and prn. - Increased staff supervision with intensity based on resident need. - Proper footwear with transfers and ambulation - Shoe rack in place. (R11) chooses to not declutter room. 2. CP dated 12/19/20: Initiated 3/1/21, revised on 5/25/21 (R11) is at risk for future falls r/t (related to) anxiety, depression, spinal stenosis, OA (Osteoarthritis), complaints of pain-migraines, antidepressant medication use, opioid medication use, antianxiety medication use, history of falls. History of a fractured humerus, right fibular, right foot, and dislocation of right shoulder joint, PVD (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 6/9/21 at 8:32 AM, the Surveyor interviewed Licensed Practical Nurse (LPN) DD regarding R11's decline in functional status. LPN DD stated R11 had two falls during the night shift hours. LPN DD did not know the details of R11's falls, indicating that she wasn't on duty at the time, but did state that R11 sustained several fractures with the falls and now requires a lot of care. On 6/10/21 at 2:37 PM, the Surveyor interviewed RN-K (Registered Nurse) regarding fall investigations. RN-K is also the facility Minimum Data Set (MDS) Coordinator. RN-K stated a complete fall investigation process is to always have a root cause analysis to determine what the resident was trying to do at the time of the fall and implement new interventions in hopes of preventing another fall from occurring. FALLS: Surveyor conducted interviews and record review with LPN CC on 6/14/21 at 1:54 PM. The following records were reviewed and discussed: Record Review: 3/1/21: 12:13 AM Incident Note . Resident was found sitting in the hallway at the doorway of the orange utility room. The nurse at the nurses' station did not hear any noises from the fall. She was sitting on her buttocks with her legs folded to the right. She denied hitting her head, she denied injuries although it was noted she had a red area on the top of her right knee. She was assisted back to her room. She was able to walk normal for self with her wheelchair . Doctor on call was notified and had no new orders. Power Of Attorney (POA) was notified . The fall occurred on 2/28/21 at 11:00 PM, as learned through review of Interdisciplinary Team Progress Notes; There was no root cause analysis. There were no new interventions put into place in attempts to prevent another fall and a fall risk assessment was not completed at the time of the fall. LPN CC stated (R11) sustained a bruise to her right knee. The next shift started and the nurse coming on duty completed a neurological assessment following the fall. The risk assessment report was dated 3/6/21, 5 days after the fall. LPN CC was asked what the process was following a resident fall. LPN-CC stated The nurse should have determined a root cause analysis and implemented a new intervention based on that root cause, in order to attempt to prevent another fall occurring. That is the standard. On 3/1/21 at 12:35 AM, it was noted R11 had worsening pain in the right arm. The doctor ordered R11 to be seen in the ER (emergency room .) However, there was no note corresponding to this order and no evidence that R11 was seen in the ER. 3/1/2021 5:32 AM: Incident Note . Resident was found on the floor near the doorway of her room. She was screaming in pain that her arm hurt. She denied pain elsewhere. She was on her left side on the floor with her right arm draped over her right hip/thigh. She said she couldn't move it. She had no shoes or socks on. Her skirt was in the bathroom. The wheel chair and walker were underneath where the TV hangs. Her POA was called and informed of injury . Report was called to the ER staff. Resident left with the EMTs (Emergency Medical Technicians) at 3:50 AM. (continued on next page)

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	525678	A. Building B. Wing	06/14/2021

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Of concern with this fall is that the incident report indicates the fall occurred at 5:32 AM, R11 left in the ambulance to be evaluated after this fall at 3:50 AM. There was no root cause analysis for this fall. At 7:05 AM, the facility received a report from the hospital nurse stating that R11 sustained several fractures as a result of this fall, including a dislocated right shoulder, a fracture of the right proximal humerus and spinal Thoracic #2 compression fracture. R11 was transferred from the local hospital to Medical Center 1 hour and 48 minutes away. At 3:52 PM the facility did implement changes and updated R11's care plan to include:, - For no apparent acute injury, determine and address causative factors of the fall. (Initiated 3/1/21) - Keep the orange utility door closed- (Initiated 3/1/21) - Make frequent checks on her at NOC (night) due to her history of pacing at night or seeking out a nurse for a snack or due to complaints of a headache. (Initiated 3/1/21) - Offer/provide assist with toileting as needed or as resident allows to reduce risk of falls. Initiated (3/1/21) - Replenish supply of briefs every shift to decrease anxiety related to not having them available. (Initiated 3/1/21) R11 returned to facility on 3/4/21 at 1:00 PM. R11's POA decided on no surgical interventions. The following Medical Diagnoses were added to R11's diagnosis listing following this fall: - Nondisplaced Fracture of Lateral Malleolus of the Right Fibula (outer right ankle) - Displaced (moved out of its normal position) Fracture of the Greater Tuberosity of the Right Humerus (right shoulder) - Displaced Fracture of the Upper End of the Right Humerus (right shoulder) - Dislocation of the Tarsometatarsal Joint of the Right Foot (junction between the midfoot and the forefoot) - Wedge Compression Fracture of the Second Thoracic Vertebra On 3/5/21 the facility completed a Fall Risk Evaluation and scored R11 as 27, indicating At Risk. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	3/5/2021 8:50 PM: Incident Note . Unwitnessed fall. Resident was noticed by writer as resident was sitting on the floor in the hall outside of her room. She said she got out of bed on the floor and scooted herself into the hall. CNA had just recently left resident room to let nurse know (R11) wanted to talk with the nurse. (R11) did not wait for nurse to go to her room . Resident had pulled out her catheter during incident. No blood noted. No injuries noted. Catheter reinserted after discussion with POA . PCP (Primary Care Provider) via fax and DON (Director of Nursing) also updated . Care plan updated with the following: - Resident has a bed alarm to alert staff to attempts to get up without assistance. (Initiated 3/6/21, Discontinued 3/29/21) - Encourage/remind to use call light to call for assistance, resident often refuses to use call light- (Initiated 3/8/21) When asked by Surveyor, LPN CC stated there was no fall investigation or Risk assessment completed at the time of the incident. On 3/9/21, the facility rearranged R11's room to place the bedside table closer to her as she could not reach her water with the alarming floor mat next to her bed. This note entered at 11:39 PM states that R11 . does not generally sleep through the whole night and that is her normal routine even when she was up and about. There was no record of increased monitoring of R11 during night hours. 3/11/2021 at 12:30 AM: Incident Note . Resident was found at approximately 12:30 AM laying supine on the floor in front of her bed. Resident was laying on her floor alarm that was not alarming. Batteries were switched out, floor mat was changed twice due to faulty alarms not sounding. When asked what resident was doing, stated that one (leg) is heavy and I am trying to make it lighter Resident was last checked on at 2345 (11:45 PM), resident was laying in bed. Resident denied having any new pain or discomfort. DON, POA, and MD was notified. Immediate intervention was finding a floor mat that works. The Surveyor asked LPN-CC what the alarm checking system is to ensure alarms are functioning properly. LPN-CC stated The staff are supposed to check that alarms are functioning properly each time they visit the room. There is no place to document that staff have checked the alarms with all cares, that I am aware of. There is no place on the MARs (Medication Administration Records) or TARs (Treatment Administration Records) for nursing to sign off, and no place for CNAs (Certified Nursing Assistants) to document that they checked the alarms with cares. (continued on next page)

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	525678	A. Building B. Wing	06/14/2021

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F 0689 Level of Harm - Actual harm Residents Affected - Few	4/18/2021 at 3:34 AM: Incident Note . Resident found on floor of hallway in front of her doorway. Resident said she had spilled some water on the floor and was trying to get some help to clean it up. She said she scooted on her buttocks to the hallway where she was found by staff. Resident had pulled her catheter out when she crawled out of bed. Catheter was replaced once resident was assessed for injuries and placed back into bed. Resident was assisted off of floor with a hoyer. On call notified, primary updated via fax, POA notified. Vitals and neuros within normal limits. Will continue to monitor. Note: There was no new intervention with this fall. 5/31/2021 at 11:50 PM: Incident Note . Resident heard calling out for help. She was found sitting on the floor in the hallway outside of her room. She was upright with her legs curled underneath her. She stated she had fallen out of bed. She was unable to explain what she needed. She had pulled out her Foley and it was laying on the floor next to her bed with balloon inflated . She had a slipper on one foot and a gripper sock on the other foot . Denies any pain other than a headache . No injuries noted . There was no new intervention following this fall. The 'Immediate action taken' according to the Risk Assessment was Resident assisted off the floor with the hoyer lift and placed back into bed. Care plan update on 6/1/21 include: - Bed to be in low position during HS (Hour of Sleep) and NOC (night) shift. (Initiated 6/1/21) The facility did not conduct thorough fall investigations to include root cause analysis, falls risk assessments or implement new interventions. The facility did not increase monitoring of resident during evening hours despite knowing resident did not sleep all night and a majority of her falls occurred during that time, as indicated on the CP intervention dated 3/1/21

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	525678	A. Building B. Wing	06/14/2021

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22548 Based on observation, record review, policy review, and interview the facility did not identify, assess cause, and implement interventions to maintain adequate nutritional status for 1 out of 1 sampled residents (R31) reviewed for weight loss. R31 had a 11.97% weight loss over 54 days since admission. The facility had not identified the weight loss, had not informed the Registered Dietician (RD) to assess and implement care plan changes, and had not consulted with the medical provider. This is evidenced by: On [DATE], Surveyor requested and received the facility policy titled Weight Assessment and Intervention. Noted in the policy was newly admitted residents will be weighed the day of admission, the next day, and weekly for two weeks thereafter. The policy further reads if there are no weight concerns, weights will be obtained monthly. The policy also noted if there are any weight variances of 5% or more from the last weight, the resident will be weighed again the next day. If weight variances continue, the RD and nursing leadership will be notified in writing. The policy noted the RD will respond to the weight variance within 24 hours. The policy continues to read assessments to be completed and analyzed by the interdisciplinary team followed by causes and changes to the care plan if any. The policy continues to read the medical provider will be consulted with the interdisciplinary team's recommendations and findings. R31 was admitted to the facility for rehabilitation on [DATE] with the following, but not all inclusive, diagnoses: protein malnutrition, chronic kidney disease, diabetes, asthma, and atrial fibrillation. Review of the weight flow sheet noted R31 weighed: ~259.8# on [DATE]. ~228# on [DATE]. ~230# on [DATE]. ~229# on [DATE]. ~228# on [DATE]. The facility did not weigh R31 as described in the facility policy, thus did not identify and act on R31's weight loss. Surveyor requested and reviewed R31's historical weights and noted R31's usual body weight over the past year was 240# to 250#. R31 had a gradual weight loss of 10# from May, 2020 to November of 2020. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the physician orders upon admission noted R31 was on an 1800 calorie diabetic diet with an additional 2 ounces of protein. R31 was not prescribed any medication to treat depression; however was taking Trazodone (an antidepressant) to treat insomnia. The facility completed an admission MDS (Minimum Data Set) assessment on [DATE] for R31 and noted the following: ~vision severely impaired. ~able to make self understood and understand others. ~BIMS (brief interview for mental status) scored a 12 out of 15 indicative of minimal cognitive deficits. ~weighed 260# and had no significant weight loss or gain. ~required extensive staff assist for eating. ~no mood indicators; however the interview was conducted prior to his wife's death. The facility developed a care plan on [DATE] titled potential nutritional problem . The care plan identified R31 liked meat and potatoes and disliked all green vegetables except lettuce. Care plan interventions included for staff to monitor and report any malnutrition signs such as refusing to eat, weight loss, and muscle wasting. On [DATE] at 11:32 a.m., Surveyor observed R31 eating lunch. R31 was served chicken, green beans, fruit, and juice. R31 required staff to set up and describe his meal tray using a clock pattern. R31 independently ate ,d+[DATE]% of this meal. Surveyor asked R31 about his lunch and R31 stated the chicken lacked flavor and was very dry and only ate a few bites. R31 stated he does not like most green vegetables and did not eat the green beans. Surveyor interviewed R31 on [DATE]. R31 stated he had lost a significant amount of weight and attributed the weight loss to a poor appetite. R31 stated while hospitalized , he was treated for an infection and was very ill. R31 stated the illness and infection may also have changed his appetite. R31 also stated his wife of 60 plus years died in May, 2021 during the time when R31 was also very ill and recovering at the nursing home. R31 stated he was unable to help his wife during her time of illness and felt sadness because of this loss. R31 stated the facility does not always serve me foods I like and I don't like to ask for an alternate. Surveyor asked if the poor appetite was attributed to his grief over the loss of his wife. R31 stated he was grieving his wife, but denied the grief contributed to his weight loss. R31 stated again the food that was served just was not palatable so he does not eat. (continued on next page)

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	525678	A. Building B. Wing	06/14/2021

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 9:15 a.m., Surveyor interviewed RD-G regarding R31's weight loss. RD-G stated she had not been aware of R31's weight loss. RD-G stated the weights are monitored by nursing and when a weight variance of 5% or greater was detected, nursing must notify the RD via email or telephone. RD-G stated once aware of the weight variance, she would complete a thorough assessment and make recommendations for the medical provider to approve. RD-G stated she was also not aware of R31's skin problems which would also trigger a nutritional assessment to aide in healing of the wounds. RD-G stated she would contact nursing to confirm R31's weight variance and skin problems and immediately complete a nutritional assessment with recommendations to be submitted to the medical provider. Review of R31's progress notes reflected RD-G nutritional assessment and medical providers recommendations. On [DATE] at 3:28 p.m., Surveyor interviewed Registered Nurse(RN) K regarding R31's weight loss. RN-K stated she was unaware of R31's weight loss. RN-K stated weekly the IDT (interdisciplinary team) meets to discuss any resident with weight loss or skin problems. RN-K stated the IDT had not discussed R31's weight loss but did discuss R31's foot ulcers that developed on [DATE]. RN-K stated the IDT meeting was not documented in the resident's medical record. RN-K stated she prepares for this meeting by reviewing a weekly weight variance report and will bring new or existing weight concerns to the IDT meeting for discussion and action. RN-K stated after she reviewed R31's weight loss, she believed the initial weight of 259# was inaccurate; however RN-K had no evidence to support this theory. Based on historical weights and hospitalization , the 259# was consistent with his past weights. RN-K stated the facility policy was to weigh each new admission upon admit and then daily for two more days, then weekly for four weeks. RN-K stated R31 was not weighed according to the facility policy or expectation, thus the weight variance was unclear and not recognized. RN-K confirmed the facility had not recognized R31's weight loss since admission, had not informed the RD of the weight loss, had not implemented interventions to prevent further weight loss, and had not consulted with the medical provider regarding the weight loss.

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	525678	A. Building B. Wing	06/14/2021

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F 0725 Level of Harm - Actual harm Residents Affected - Few	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** 30570 Based on observation, record review, and staff and resident interviews, the facility did not ensure they had sufficient nursing staff to provide nursing care and services to all the residents and assure resident safety as determined by resident assessments and individual plans of care and considering the number, acuity, and diagnoses of the facility's resident population in accordance with the required facility assessment. This has the potential to affect all 54 residents residing in the facility. Example#1: The facility did not ensure 8 of 14 residents (R2, R18, R21, R34, R15, R10, R3, R48) received prompt response to their needs and call lights due to insufficient staffing as voiced during individual resident interviews and resident group meeting. Example #2: The facility did not ensure residents reviewed for falls (R33) received adequate supervision and assistive devices to prevent accidents due to lack of sufficient direct care staff. Example #3: The facility did not ensure 1 of 3 residents reviewed for Pressure Injuries (PI) (R21), received adequate repositioning due to lack of sufficient staffing. Example #4: The facility did not provide adequate Activities of Daily Living (ADLs) cares for 1 of 12 residents (R2) dependent on staff cares due to insufficient staffing. Example #5: The facility did not ensure dignified care due to insufficient staffing for 3 residents (R2, R18, and R21). Example #6: The facility did not provide the nurse staffing considering the number, acuity and needs of the facility's resident population in accordance with the required facility assessment. This is evidenced by: The Surveyor reviewed the facility completed Resident Census and Conditions of Residents (CMS-672) for the entrance date of the survey of 6/8/21 and noted the current resident information: (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	Census: 54 Bathing: 0 independent, 49 assist with one or two staff, 5 dependent Dressing: 1 independent, 51 assist of one or two staff, 2 dependent Transferring: 4 independent, 42 assist of one to two staff, 8 dependent Toilet Use: 1 independent, 52 assist of one to two staff, 1 dependent Eating: 24 independent, 29 assist of one or two, 1 dependent Catheters: 5 Occasionally or frequently incontinent of bladder: 42 Occasionally or frequently incontinent of bowel: 27 Urinary toileting program: 6 Bowel toileting program: 5 Ambulation with assistance or assistive device: 16 Dementia: 19 Behavioral healthcare needs:18 Pressure Injury, excluding Stage I: 4 IV: 1 Staff Posting for this date was reviewed on Tuesday 6/8/21 at 8:17 AM: Dayshift: 6AM - 2 PM: RNs- 2 (16 hours), CNAs- 3 (24 hours), other (Nurse grad) 1 (8 hours) Evening Shift: 2 PM -10 PM: RN- 1 (8 hours), LPN-1 (4 hours), CNAs- 4 (22 hours), other (nurse grad)- 1 (4 hours) Night Shift: 10 PM - 6 AM: RNs -1 (4 hours), LPNs- 2 (16 hours), CNAs- 2 (16 hours) Example #1 Interviews (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	On 06/08/21 at 2:03 pm the surveyor spoke with CNA AA. CNA AA explained she is the only full time nurse aide on the pm shift. The facility attempts to schedule 3 nurse aides on pm shift. Often it is a.m. staff staying over and night shift coming in early. CNA AA expressed residents are not toileted and repositioned as they should be. Resident showers are not given as scheduled. A weekly shower list is used. Each week a new one is put out for staff to highlight and initial when shower is done for the week. If the shower is not given on the scheduled night, staff try to make it up another day but often are not able to. Residents are going greater than a week without a shower. Office staff help out by passing meal trays and nurses try to help out as able. The facility is trying to hire staff but nurse staffing has gotten progressively worse since hired last December. On 06/09/21 at 9:52 a.m. the surveyor spoke with Certified Nursing Assistant (CNA) M. CNA M expressed the facility is currently scheduling 3 nurse aides on am and pm shift for 4 floors and 50+ residents. CNA M further expressed it is impossible to respond to call lights timely when the CNA is pulled off one floor to assist on another floor. Often the CNA is absent from the floor for long period of time which causes long wait times for residents to have their needs met. The surveyor asked CNA M if residents are having to wait one hour or greater. CNA M responded she has heard residents complain that they have had to wait over an hour. On 6/14/21 at 11:10 am the surveyor spoke with Graduate Nurse (GN) Y regarding nurse staffing. GN Y expressed she tries to help the nurse aides as much as she can. The facility needs more help. The residents wait a long time to get their call lights answered and have their needs met. On 6/10/21 at 8:23 AM, the Surveyor interviewed Certified Nursing Assistant (CNA) O regarding the expectation of cares to residents. CNA-O stated that she makes attempts to get to residents in a timely manner, but with the staffing shortage, cannot respond to call lights timely. She indicated that sometimes the call light will be on for a while before she can respond to them, and very often more residents have an increase in incontinence as a result, causing the resident to lay in a soiled brief for a while. I feel bad for them, but I can only do so much, it's sad. On 6/10/21 at 1:18 PM, the Surveyor interviewed CNA P regarding general staffing and services provided to residents. CNA P stated she felt concerned because she is unable to provide residents with care they are deserving of. It takes a long time sometimes to answer their call lights because we are short staffed and if we are in a room taking care of someone, we cannot leave to answer call lights. So sometimes it can be one-half to one hour, sometimes longer if there are several call lights going off at one time. I feel terrible for them (residents), they deserve better care. Some nurses will help out, but others won't. We don't have all people that work here help with call lights, which is frustrating when you see people just walk past them. CNA P was asked if she had noticed some decline in residents as a result of not being able to assist them timely. CNA P stated, Oh yes, there is an increase with incontinence because we can't get them to the bathroom in time, so they have to wait for us and end up going in their pants or in bed. I apologize to them, but I know it is embarrassing for some of the residents . I just wish we could give them better care but we are so strapped and can only do so much . Resident Group Meeting On 10/09/2021 at 10:30AM, the resident group meeting was held with the Surveyor, as part of the survey process. Those with concerns who attended the group meeting included R15, R10, R48, R3, R34. All residents present with the exception of R3, attend facility Resident Council meetings regularly. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	Prior to the resident group meeting the Surveyor reviewed the past six months of meeting minutes from the facility Resident Council meetings. The minutes spoke to grievances during the meetings being given to Social Services to be followed up on. Surveyor asked to review these grievances prior to the meeting. These were reviewed and it was found that there were several grievances related to staff shortages and answering of call lights. The following questions were asked. Do you get the help and care you need without waiting a long time? Do staff respond to your call light timely? R34 stated they get help but not on time. As an example R34 stated that when they are put in the bathroom on the toilet that it takes 45 minutes for staff to answer the call light to get them off the toilet. R34 stated that this happened frequently. The average call light response time is 30 to 45 minutes. R34 stated there were way too few staff to cover the needs of the residents. R15 said that they did get showers but they were sometimes not as scheduled due to staffing issues. They added that the diet they were supposed to get was gluten and sodium free and sometimes is not. R10 commented on not getting a shower. Wait time when a call light is pulled can be very long. It can be over 45 minutes during night time cares and in requesting medications. R10 stated the average wait time for call lights was 45 minutes. R3 stated that sometimes they got what they needed, and sometimes they did not. R48 stated that they felt the staffing numbers were low because the company was trying to make money. There is only 1 nurse and 1 CNA (certified nursing assistant) on during the night shift for the entire building. This fact makes call light response even longer during those nights. The group consensus was that there was a lack of staffing due to missing showers, and the long call light response time. Example #2 - Falls R33 had a fall with multiple fractures, pain, and decline in status. R33 was hospitalized to treat the hip fracture and manage the pain associated with multiple fractures. R33 returned to the facility under Hospice services. According to the staff interviews and family interviews, this fall was a result of insufficient staffing and unmet care needs of R33. On 04/11/21, R33 had a fall and sustained a left hip fracture, T11-T12 vertebral (spine) fractures, and was hospitalized to repair the left hip fracture and manage the pain associated with the multiple fractures. R33 was readmitted to the facility on [DATE] under Hospice services due to poor prognosis following the fall. Review of the care plan titled .risk for falls r/t (related to) confusion, incontinence, unaware of safety needs, decreased vision, Alzheimer's, diuretic (water pill) use, hx (history of) falls . initiated on 01/14/21 and last revised on 05/10/21 included interventions such as anticipate and meet needs, check on resident every 1-2 hours and provide repositioning, and review information on past falls and attempt to determine cause of falls, record root cause of falls, and remove potential causes. (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	06/14/2021

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F 0725 Level of Harm - Actual harm Residents Affected - Few	Review of R33's progress notes indicated another fall on 04/11/21 at approximately 7:30 to 8:00 p.m. R33 was heard yelling for help by an adjacent resident (R16). R16 put on her call light to summon staff to help R33. RN-E, CNA-D, CNA-L, and RN-BB responded to R33's calls for help and found R33 laying on her left side with her head against the wall in the bathroom. R33 complained of pain in her left leg, left shoulder, and back with movement. RN-E stayed with R33 while RN-BB telephoned emergency services to transport R33 to the hospital for evaluation. Review of the fall incident reported noted R33's fall factors were incontinence, impaired memory, and weakness. There was no investigation into the root cause of the fall. There were no staff interviews when R33 last received staff assistance with cares. Surveyor requested a list of all staff working on 04/11/21 on the second shift and noted there was two RN (Registered Nurses) and two CNAs (Certified Nursing Assistants) for a census of 51 residents. During the survey, all four staff working on 04/11/21 were interviewed regarding the events surrounding R33's fall. All four staff reported inability to meet R33's needs due to short staffing as the cause of R33's fall and injuries. CNA-L, RN-BB, RN-E, and CNA-D reported R33 had been sitting in wheelchair since prior to supper and was likely tired and wanted to use the toilet then go to bed. RN-BB, CNA-L, RN-E, and CNA-D stated R33 was inconsistent when asking staff for assistance with toilet use. RN-BB, CNA-L, RN-E, and CNA-D also stated R33 was usually in bed between 7:00 and 7:30 p.m. On 06/09/21 at 3:00 p.m., Surveyor interviewed RN E regarding R33's care needs and fall. RN E stated she had cared for R33 since January of 2021 and primarily worked full time on the second shift. RN E stated prior to R33's fall, R33 was up in the wheelchair and would propel self throughout the facility. R33 would enjoy small group socialization and would at times eat her evening meal in the dining room. RN E stated R33 was able to make needs known, was dependent on staff for transfers, toilet use, and hygiene. RN E confirmed she was on duty on 04/11/21 and assisted R33 following the fall. RN E stated R33's fall was a result of insufficient staffing. RN E stated R33 had been sitting in the wheelchair for several hours and likely attempted to toilet self and fell . RN E stated R33 was usually in bed around 7:00 p.m. RN E stated usual staffing pattern for the second shift was 2 nurses and 2 CNAs (Certified Nursing Assistant) for an average census of 50 or more. RN E stated all staff try to provide good care, but residents have to wait for call light response, help with toileting, and help getting ready for bed. RN E stated all staff are frustrated because there isn't enough help and the facility continues to take new admissions. RN E stated staff try hard to get the work done, but just can't when there are only 2 CNAs. RN E stated showers, oral hygiene, toileting, and repositioning are not getting done because of not enough staff. On 06/9/21 at 7:15 p.m., Surveyor interviewed CNA D who confirmed she worked on 04/11/21. CNA D stated she had not provided any care for R33 since she arrived at the facility around 6:00 p.m. CNA D stated there were only 2 CNAs on for the second shift on 04/11/21. CNA D stated insufficient staffing was a factor in R33's fall because staff could not help her to the toilet after supper and R33 likely attempted to toilet self and fell . (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	On 06/14/21 at 11:15 a.m., Surveyor interviewed CNA L who confirmed he worked on 04/11/21. CNA L stated R33 was a quiet, private, and reserved resident who would propel herself in the wheelchair throughout the facility. CNA L stated R33 needed help with all ADL (activities of daily living) and was unsafe to transfer independently. CNA L stated R33 had been up in the wheelchair since before supper and had likely wheeled self into the bathroom and attempted to toilet self and fell . CNA L stated R33's usual bedtime routine was to use the toilet, wash up, brush her teeth, and settle into bed around 7:00 p.m. CNA L stated the insufficient staffing was absolutely a factor in R33's fall. CNA L stated the short staffing problem was a factor in other resident falls as well. 6/14/21 at 4:00 p.m., Surveyor interviewed RN BB via telephone regarding R33. RN BB stated she has worked at the facility for approximately 6 months full time on the second shift. RN BB stated she was familiar with R33's care needs. RN BB stated R33 required extensive to total staff assist for all ADL (Activities of Daily Living) needs. RN BB stated R33 was able to make basic needs known and would sometimes use call light to ask for staff assistance, but was not consistent in the use of a call light. RN BB stated R33 preferred to be assisted into bed before or near 7:00 p.m. RN BB stated R33 had a fall on 04/11/21 when she attempted to toilet self. R33 was found in the bathroom on the floor. RN BB stated she was called to assist RN E, CNA D, and CNA L assess R33 following the fall. RN BB stated R33 was unable to move without significant pain in her leg, back, and shoulder. RN BB stated R33 remained on the floor with staff present until emergency services arrived and transported R33 to the hospital. RN BB stated the contributing factors for R33's fall with injury and pain were R33's dementia and the lack of sufficient staffing in the building. RN BB stated R33's fall was likely avoidable had staff assisted R33 with toileting and then into bed prior to 7:00 p.m. RN BB stated R33 had likely been sitting in the wheelchair since before supper and was incontinent of urine and needing to be repositioned. RN BB stated staff are unable to assist resident with repositioning and toileting needs timely which was a significant factor in R33's fall along with other residents' falls. Example #3- Pressure Injuries R21 is a high risk for the development of PI's (Pressure Injuries) with a former history of one to her buttocks. She is to be a check and change and repositioned every two hours. An observation was made on 6/9/21 in which this was not completed by staff for a time period of 3 hours 42 minutes. According to the most recent Minimum Data Set Assessment (MDSA) completed for R21, which was a Significant Change in Status assessment dated [DATE] related to R21 enrolling in Hospice Services, R21 requires extensive assistance of two staff to meet her most basic daily tasks of bed mobility, dressing and toilet use. She requires extensive assistance of one staff to meet tasks such as transfers and personal hygiene. She is non-ambulatory and frequently incontinent of bowel and bladder function. The Surveyor conducted a brief record review of R21 and noted Care Plans (CP) in place direct staff to reposition R21 every two hours and resident is toileted by a check and change process. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	6/8/21 at 10:27 AM, R21 stated that she needs to wait upwards of two hours for assistance when she activates her call light. R21 also stated that often she wets her incontinent brief several times before she receives assistance. Surveyor conducted a continuous observation of R21 on 6/9/21 from 9:45 AM - 1:27 PM (3 hours, 42 minutes) in which no staff entered her room to offer or assist R21 with toileting or repositioning, even though R21 is a high risk for the development of PI's. At 1:27 PM CNA W entered R21's room and then offered to assist her to the bed. At that time CNA W provided perineal cleansing for R21 after removing a heavily urine saturated brief. R21's buttocks and front perineum were dark red. CNA W verified that R21 was to be checked and repositioned every two hours but . because I am watching two wings, . things are a little behind. Example #4 - ADL's On 06/08/21 at 1:34 pm the surveyor spoke with R2. R2 indicated she is supposed to get a full bed bath every Friday am but does not. R2 further expressed she gets a bed bath every couple of weeks. R2 further expressed she is unable to get supplies and complete the bed bath on her own. She is blind and bedridden for the most part. R2 further expressed staff change her diaper in the morning and evening but most often do not wash her up. The bed bath is needed each week to feel clean. R2 told the surveyor her teeth are not brushed by staff each day. R2 expressed she depends on staff to provide her with toothbrush with paste for her to brush teeth. Staff need to help her brush her teeth as she is blind and not sure she is doing a good job. Need staff to provide cup of water to rinse mouth and basin to spit. She can not get up on own to get supplies, cannot fill a glass with water and cannot do a thorough job brushing teeth. Further expressing she needs staff to help and has lost teeth in the past due to poor hygiene. R2 further expressed she is provided supplies and assisted with brushing her teeth about one time a month for the past year. R2 expressed her teeth feel grimy and she has resorted to cleaning her teeth by picking at them with her fingernails and wiping her teeth with a Kleenex. R2 further expressed she has had 4 teeth removed since living at the facility about a year ago due to poor oral hygiene. R2 indicated her cares are not being done adequately due to lack of sufficient staff. On 06/09/21 at 10:07 am the surveyor spoke with Certified Nursing Assistant (CNA)-M regarding R2's cares. CNA-M indicated she is familiar with R2. CNA-M expressed she completes R2's bed bath on Friday a.m. when she is assigned the 100 unit. CNA-M further expressed CNAs are often unable to complete thorough cares; including bed baths, due to being rushed to complete cares for too many residents. The facility is currently staffing 3 CNAs for 4 units of 50+ residents. Staff try their best but can not get everything done as thorough as it should be for the residents. CNA-M also indicated resident toothbrushing is often one of the things the aides do not have time to do because of rushing with cares and lack of staffing. 6/09/21 at 2:45 p.m. the surveyor requested and received R2's data for bed baths since 1/01/21. The data verifies R2 has not received a weekly bed bath as indicated in her plan of care. Example #5 - Dignified Care (continued on next page)

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	525678	A. Building B. Wing	06/14/2021

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F 0725 Level of Harm - Actual harm Residents Affected - Few	On 06/08/21 at 1:50 p.m. the surveyor spoke with R2. R2 indicated she is blind and bedridden for the most part. R2 is unable to care for her own needs. R2 voiced feelings of humiliation due to having to lay in bowel movement as staff are unable to respond to her call light and needs promptly due to insufficient staffing. R2 indicated staff tell her they are to busy to respond to call light because there is not enough help causing R2 to lay in BM for periods sometimes greater than one hour. R2 expressed there are a lot of nurses but the facility need aides. Some nurses help, but not all. Some will not help out when you ask. Waiting over an hour full of (*X*X-expletive) bowel movement and you can't help yourself is humiliating. The surveyor reviewed R2's most recent Minimum data set completed 5/19/21 and noted the following: R2 understands, is understood and is cognitively intact. R2 is always incontinent of bowel movement and is dependent on staff for personal hygiene. R2's care plan notes: incontinent of bowel, approximately change every 2 hours and prn (as needed). On 06/09/21 at 9:52 a.m. the surveyor spoke with Certified Nursing Assistant (CNA) M. CNA M expressed the facility is currently scheduling 3 nurse aides on am and pm shift for 4 floors and 50+ residents. CNA M further expressed it is impossible to respond to call lights timely when the CNA is pulled off one floor to assist on another floor. Often the CNA is absent from the floor for long period of time which causes long wait times for residents to have their needs met. The surveyor asked CNA M if residents are having to wait one hour or greater. CNA-M responded she has heard residents complain that they have had to wait over an hour. R18 has a Brief Interview of Mental Status (BIMS) score of 13/15, indicating slight areas of confusion but overall, cognitively intact. Minimum Data Set Assessment (MDS) completed for R18, which was an admission assessment dated [DATE], include: - R18 requires extensive assistance of two staff to meet his most basic daily tasks of bed mobility, transfers and toilet use. He is non-ambulatory related to a recent hip fracture and the inability to apply direct pressure on his right leg, as well as a Stage III PI to his left heel that was recently skin grafted, thus is transferred with the use of a mechanical lift. He requires extensive assistance of one staff to meet his most basic needs of dressing and personal hygiene, and is dependent on staff for bathing. This MDSA also assessed R18 as being occasionally incontinent of bladder function and always incontinent of bowel function. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	06/08/21 at 11:03 AM, the Surveyor asked R18 if he receives care and his needs are met in a timely manner. R18 frowned and stated, There is a terrible, terrible staffing problem here. I am supposed to get the dressing on my foot (sticks out his left leg) every morning. Yesterday, they didn't come and they didn't come. Finally at 7:00 last night I asked 'when is my dressing going to get replaced?' The nurse on the evening shift finally did it. I have to direct all my own care or I wouldn't get taken care of the way I am supposed to. They don't either follow the orders the doctor has written, or they have no time to read them. Last night, I put on my call light a little after 7:00, after the nurse did my treatment. I had to go diarrhea. When I need to go, I need to go NOW. I tried to hold it, but finally it flowed like the Niagara falls out of me. That was after 1 hour and 10 minutes of waiting for someone to answer my call light. If you don't think that was embarrassing. Just terrible to s--- (expletive) your pants and have to lay in it until some young chickie comes and has to clean you up. Horrible! I am a grown man, and let me tell you, taking a dump in your pants is a most horrific feeling . right now, I am paying for the full load. I just wrote them out a check .the other day. I don't mind paying for it, but the expectation is that with that amount of money, I damn well better get better care than I am at this point. I will pay whatever is needed, but I expect better service than laying in s--- (expletive) for over an hour! Minimum Data Set Assessment (MDSA) completed for R21, which was a Significant Change in Status assessment dated [DATE] related to R21 enrolling in Hospice Services, R21 requires extensive assistance of two staff to meet her most basic daily tasks of bed mobility, dressing and toilet use. She requires extensive assistance of one staff to meet tasks such as transfers and personal hygiene. She is non-ambulatory and frequently incontinent of bowel and bladder function. The facility conducted a Brief Interview of Mental Status (BIMS), which scores the individual's cognitive function, and scored R21 as 9/15, indicating moderate impairment. The facility also conducted a PHQ-9 (Patient Health Questionnaire) which assesses each of the 9 DSM-IV (Diagnostic and Statistical Manual of Mental Disorder) criteria. R21 scored 8/27, which indicates mild depression. During the screening process on 6/8/21 at 10:27 AM, the Surveyor asked R21 if she receives care and her needs are met in a timely manner. R21 shook her head and stated, I feel they really need help badly. There are times I do have to wait upwards of two hours for help. Once I laid in my soiled diaper in bed for over two hours with my call light on. I soiled several times in that same incontinent product before someone came to help me. I think I would have been able to go on the toilet had someone come in when I put on my call light. Sometimes it is frustrating. That was very embarrassing for me, having to have young girls clean up a soiled diaper of an old lady. They are short staffed like everyone else in this country right now, people don't want to work . Sometimes the girls get short with us and say they can't help that they can't provide better service because they are short staffed, and will get grumpy. I just tell them, 'Well, I am not receiving the services I would want either, we're all in the same boat. I have to wait until they help me. They don't let me get out of my wheelchair by myself, but yet, they don't walk me in the hall either, so that I can get stronger. They don't have enough staff to do that, so I sit here, all day, just waiting. I guess I could put on my call light and ask for help, but I feel so bad for them. They just don't have the time . (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	On 6/10/21 at 1:18 PM, the Surveyor interviewed Certified Nursing Assistant (CNA) P regarding general staffing and services provided to residents. CNA P stated she felt concerned because she is unable to provide residents with care they are deserving of. CNA P stated, It takes a long time sometimes to answer their call lights because we are short staffed and if we are in a room taking care of someone, we cannot leave to answer call lights. So sometimes it can be one-half to one hour, sometimes longer if there are several call lights going off at one time. I feel terrible for them (residents), they deserve better care. Some nurses will help out, but others won't. We don't have all people that work here help with call lights, which is frustrating when you see people just walk past them. Example #6 - Nurse Staffing per Facility Assessment The surveyor requested and reviewed the Facility Assessment Tool which notes the following: Requirement: Nursing facilities will conduct, document and annually review a facility-wide assessment, which includes both their resident population and resources the facility needs to care for their residents. Purpose: The purpose of the assessment is to determine what resources are necessary to care for residents competently during day to operations. Use the assessment to make decisions about your direct care staff needs as well as your capabilities to provide services to the residents of your facility. Date of assessment update: most recently on 4/21 Date reviewed by QAA/QAPI committee: 5/21 Indicate average daily census: 49-53 Consider if it would be helpful to describe the number of persona admitted and discharged , as these processes impact staffing needs: Weekly: Number (average or range of persons admitted) : 2-3, Number (average or range of persona discharged : 2-3 Evaluation of overall number of facility staff to ensure a sufficient number of qualified staff are available to meet each residents needs. Census: 42 RN: AM: 2, PM: 2 and Nights: 1 CNA: AM: 3.5, PM: 3.5 and Nights: 3 Total Nursing Staff: AM: 5.5, PM: 5.5 and Nights: 4 Total Nursing staff in a 24 hour period=15 *Of note 1 staff is equal to a 8 hour shift (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	Census of 50=addition of 3 nursing staff, for a total of 18 nursing staff in a 24 hour period Census of 53=addition of 4 nursing staff, for a total of 19 nursing staff in a 24 hour period Census of 56=addition of 5 nursing staff, for a total of 20 nursing staff in a 24 hour period Census of 59=addition of 6 nursing staff, for a total of 21 nursing staff in a 24 hour period The surveyor requested and reviewed the facility resident census reports since 4/21/21. The surveyor noted a range of 50 to 57 residents. The average daily census was 53.69 residents from 4/21/21 through 6/14/21. The surveyor requested and reviewed the nurse staff postings form 4/21/21 to 6/14/21 and noted the information did not include staff actual hours worked and the information did not match the nursing staff schedules and nursing assignment sheets used by the facility. See F732 citation. The surveyor requested and reviewed the nursing staff schedules from 4/21/21 to 6/14/21 and noted the schedules did not include actual nursing staff hours worked or changes that occurred during the scheduled pay period. The surveyor requested the nursing staff assignment sheets used by the facility to note actual staff working during each shift from 4/21/21 through 6/14/21 (55 days). The surveyor reviewed the following days and noted the following nurse staffing: Friday April 23, 2021: Census was 56 residents: AM nursing staff included: 3.5 CNAs and 2.5 nurses PM nursing staff included: 3 and 3 nurses Night staffing included: 2 CNAs and 1 nurse Total staffing in a 24 hour period: 8.5 CNAs and 6.5 nurses=15 nursing staff Based on the facility assessment the facility determined 20 nursing staff are needed to adequately care for 56 residents in a 24 hour period. The facility was 5 nursing staff short to meet their residents needs. Saturday April 24, 2021: Census was 53 residents: AM nursing staff included: 2.5 CNAs and 2 nurses PM nursing staff included: 2.75 CNAs and 2 nurses (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	Night staffing included: 2 CNAs and 1 nurse Total staffing in a 24 hour period: 7.25 CNAs and 5 nurses=12.25 nursing staff Based on the facility assessment the facility determined 19 nursing staff are needed to adequately care for 53 residents in a 24 hour period. The facility was 6.75 nursing staff short to meet their residents needs. Sunday April 25, 2021: Census was 55 residents: AM nursing staff included: 2.5 CNAs and 2 nurses PM nursing staff included: 2 CNAs and 2 nurses Night staffing included: 1.5 CNAs and 1 nurse Total staffing in a 24 hour period: 6.0 CNAs and 5 nurses=11.0 nursing staff Based on the facility assessment the facility determined 19 nursing staff are needed to adequately care for 53 residents in a 24 hour period. The facility was greater than 8 nursing staff short to meet their residents needs as the census was greater than 53. Friday May 28, 2021: Census was 56 residents: AM nursing staff included: 2 CNAs and 2 nurses PM nursing staff included: 3 CNAs and 2 nurses Night staffing included: 2 CNAs and 2 nurse Total staffing in a 24 hour period: 7.0 CNAs and 6.0 nurses=13.0 nursing staff Based on the facility assessment the faci [TRUNCATED]

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 30570 Based on observation, record review, and interview the facility did not include actual hours worked by nursing staff on the daily staffing hours posting. This has the potential to affect all 54 residents. The daily staffing hours posting did not include actual hours worked by nursing staff when their hours differed from the noted shift hours. This is evidenced by: On 6/08/21 the surveyor noted the nurse staffing posting on a bulletin board across from the nurses station. The posting noted the following: Date: 6/08/21 Census: 54 Day shift 6 am to 2:00 pm RN (Registered Nurse) Total Number of staff: 2, Total hours worked: 16 LPN (Licensed Practical Nurse): 0, Total hours worked: 0 CNA (Certified Nursing Assistant): 3, Total hours worked: 24 Other/Med. Tech/Nurse Grad.: 1, Total hours worked: 8 PM shift 2 pm to 10:00 pm RN (Registered Nurse) Total Number of staff: 1, Total hours worked: 8 LPN (Licensed Practical Nurse): 1, Total hours worked: 4 (no actual hours noted) CNA (Certified Nursing Assistant): 4, Total hours worked: 22 (no actual hours noted) Other/Med. Tech/Nurse Grad.: 1, Total hours worked: 4 (no actual hours noted) Night shift 10 pm to 6 am RN (Registered Nurse) Total Number of staff: 1, Total hours worked: 4 (no actual hours worked) LPN (Licensed Practical Nurse): 2, Total hours worked: 16 CNA (Certified Nursing Assistant): 2, Total hours worked: 16 Other/Med. Tech/Nurse Grad.: 0, Total hours worked: 0 (continued on next page)

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	525678	A. Building B. Wing	06/14/2021

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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	On 6/09/21 the surveyor noted the nurse staffing posting on a bulletin board across from the nurses station. The posting noted the following: Date: 6/09/21 Census: 53 Day shift 5:45 am to 2:00 pm RN (Registered Nurse) Total Number of staff: 2, Total hours worked: 16 LPN (Licensed Practical Nurse): 1, Total hours worked: 8 CNA (Certified Nursing Assistant): 3, Total hours worked: 24 Other/Med. Tech/Nurse Grad.: 0, Total hours worked: 0 PM shift 1:45-10:00 pm: RN (Registered Nurse) Total Number of staff: 1, Total hours worked: 8? (no actual hours worked) LPN (Licensed Practical Nurse): 1, Total hours worked: 8 CNA (Certified Nursing Assistant): 3, Total hours worked: 16 Other: hospitality: 1, Total hours worked: 8 Night shift 9:45 pm to 6 am: RN (Registered Nurse) Total Number of staff: 0, Total hours worked: 0 LPN (Licensed Practical Nurse): 1, Total hours worked: 8 CNA (Certified Nursing Assistant): 3, Total hours worked: 24 Other: 0, Total hours worked: 0 On 6/10/21 the surveyor noted the nurse staffing posting on a bulletin board across from the nurses station. The posting noted the following: Date: 6/10/21 Census: 53 Day shift 6 am to 2:00 pm RN (Registered Nurse) Total Number of staff: 3, Total hours worked: 24 LPN (Licensed Practical Nurse): 0, Total hours worked: 0 CNA (Certified Nursing Assistant): 3, Total hours worked: 24 (continued on next page)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Other/Med. Tech/Nurse Grad.: 0, Total hours worked: 0 PM shift 2 pm to 10:00 pm: RN (Registered Nurse) Total Number of staff: 1, Total hours worked: 4 (no actual hours worked noted) LPN (Licensed Practical Nurse): 3, Total hours worked: 16 (no actual hours worked noted) CNA (Certified Nursing Assistant): 3, Total hours worked: 16 (no actual hours worked noted) Other: hospitality: 1, Total hours worked: 8 Night shift 9:45 pm to 6 am: RN (Registered Nurse) Total Number of staff: 0, Total hours worked: 0 LPN (Licensed Practical Nurse): 2, Total hours worked: 16 CNA (Certified Nursing Assistant): 2, Total hours worked: 16 Other: 0, Total hours worked: 0 On 6/10/21 the surveyor requested staff hours postings from 4/21/21 to present. The surveyor noted the postings much the same as posted on 6/08/21, 6/09/21 and 6/10/21. The postings did not note actual hours worked when staff hours were noted as less than 8 (a partial shift). The surveyor also noted inconsistencies with the hours of the actual am, pm, and night shift. On 6/10/21 at 9:18 a.m. the surveyor spoke with the Director of Nursing (DON)-B regarding the nurse staffing hours posting. DON-B indicated she is responsible for the daily nursing staff posting. DON-B verified the am shift as 6 am to 2 pm, the pm shift as 2 pm to 10 pm and the night shift as 10 pm to 6 am. DON-B indicated she was unaware the postings required actual staff hours when staff work hours other than the full shift. DON-B further indicated she was accurately trained when she took over the task and was not aware of the requirements.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22548 Based on observation, record review, policy review, and interviews the facility did not prepare, store, and serve food under sanitary conditions. This has the potential to affect all 54 residents. The facility served leftover meals and does not have a process to cool foods out of the danger zone. The facility did not ensure dishes were properly sanitized using the correct temperatures. The facility was not testing the temperature of cold food items such as beverages and desserts served to residents. Cook-H and DA (Dietary Aide)-J were not wearing hair restraints while cooking, plating, distributing food and cleaning dishes on [DATE] and [DATE]. This is evidenced by: Cooling Procedures On [DATE] Surveyor observed a sealed container of spaghetti in the cooler. The spaghetti was dated [DATE]. Cook I heated and served the leftover spaghetti to nine residents for lunch on [DATE]. On [DATE] at 10:45 a.m., Surveyor requested the cooling logs and Cook I stated there was no cooling logs for the leftovers served yesterday. Surveyor continued to review the menu and noted the alternates served were leftovers. Cook I made cheesy potatoes, corned beef, and mexican corn on [DATE] for the evening meal and these items were leftover and served on [DATE]. There is no evidence of these food items being properly cooled. Cook I was interviewed about the cooling process of the cheesy potatoes, corned beef, and mexican corn. Cook I stated he did not record any temperatures. On [DATE], Surveyor requested and reviewed the facility policy on cooling procedure and serving leftover foods. The policy reads Potentially hazardous foods should be cooled rapidly. This is defined as cooling from 135 degrees Fahrenheit to 70 degrees Fahrenheit within two hours and then to a temperature of below 41 degrees Fahrenheit within the next 4 hours. Dishwashing Machine Surveyor requested and reviewed the facility policy titled Dishwashing Machine Use. The policy read the dishwashing machine will be checked weekly for proper sanitization and recorded on the facility log. The policy read for hot water machines the wash cycle must reach 165 degrees Fahrenheit and the rinse cycle must reach a temperature of 180 degrees Fahrenheit. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 10:23 a.m., Surveyor observed DA J wash dishes using a [NAME] hot water dish machine. The [NAME] machine read for wash cycle the hot water must reach 165 degrees Fahrenheit and the rinse water temperature must reach 180 degrees Fahrenheit. Surveyor reviewed the temperature logs and noted there was no evidence of the temperature test strip. Surveyor asked DA J if the facility checked the temperature of the dish machine using a test strip. DA J stated yes it was checked weekly. Surveyor asked where the results were recorded and DA J stated there was no record of the dish machine test strips. Surveyor asked to see the product used to check the dish machine temperature and 2 packets of test strips were provided. The first packet was expired [DATE] and the second packet was expired on [DATE]. The strips that expired in 2020 were not rated for a temperature of 180 only for a temperature of 160. On [DATE] at 10:30, Cook I showed Surveyor 2 months of dishwasher temperature logs that included the test strip. According to the [NAME] specifications, the rinse must reach 180 degrees Fahrenheit to ensure proper sanitizing of the dishes. Review of the weekly temperature test strips for March and April noted the temperature ranged from 165 to 170 and never reached the proper temperature for sanitizing. Food temperatures On [DATE] at 9:59 a.m., Surveyor interviewed DA J regarding cold food temperatures. DA J stated he never checks the temperature of the milk or juice that was served to the residents in the dining room. DA J stated either the cook or the aide will check the prepoured liquids that are served to residents who eat in their rooms. Surveyor observed breakfast and lunch twice and the temperature of the cold food items were not checked. On [DATE], DA J served lunch to 18 residents in the dining room without checking the cold food temperatures of the vanilla mousse, milk, and juices. DA J also served the room trays to the remaining residents without checking the temperature of the vanilla mousse. Hair Restraints On [DATE], Surveyor noted Job Description that was posted on the wall as you enter the kitchen. The posting read for dietary aides .put on hair net . On [DATE] beginning at 8:05 a.m., Surveyor observed DA J serve breakfast to all residents in the dining room and eating in their rooms. DA J was not wearing a hair net. DA J had a full head of white hair and there was no hair net worn. On [DATE] at 10:23 a.m., Surveyor observed Cook H in the kitchen putting away the weekly food delivery and was not wearing a hair net. Cook H stated he shaved his hair so he does not have to wear a hair net. Cook H stated he was told if the hair was shaved or real short a hair net was not required. On [DATE] and [DATE], Surveyor observed Cook H prepare food (fruit and vegetables) and plate food without a hair net. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] and [DATE], Surveyor observed DA J serve food in dining room and load food carts for residents who eat in the rooms, pour fluids (milk and juice), plate dessert (vanilla mousse), set tables, run the dishwasher, and put away clean dishes without wearing a hair net. On [DATE], Surveyor requested and reviewed the facility policy on hair restraints. The policy reads Food and nutrition services staff shall wear hair restraints .so that hair does not contact food. The policy titled Preventing Foodborne Illness-Food Handling bullet point #12 reads Hair nets or caps and/or beard restraints must be worn to keep hair from contacting exposed food, clean equipment, utensils and linens. On [DATE] at 9:15 a.m., Surveyor interviewed Registered Dietician (RD) G regarding kitchen observations and deficient practice. RD G stated foods should be cooled to at least 70 degrees Fahrenheit within 2 hours and to 41 degrees Fahrenheit within the next 4 hours to reduce the risk of food borne illnesses. RD G stated leftovers could be heated only once then discarded after that serving. RD G was unaware the facility was not completing the cooling process in accordance with the policy. RD G stated the facility does use leftovers frequently but must discard leftovers after 3 days and follow proper cooling procedures. RD G stated education was provided to Cook H regarding menu substitutions, cooling procedures, and therapeutic diets. RD G stated dishwasher temperatures were to be tested at least weekly and recorded on the temperature flowsheets. RD G was unaware the test strips had expired in February, 2020. RD G stated she was unaware the dishwasher was not being tested at least weekly. RD G stated checking the proper sanitization for all dishes and utensils was required to reduce the spread of infection. RD G stated all foods, hot or cold, are to be checked for proper temperature shortly before serving to ensure palatable and safe foods. RD G stated the goal of cold foods at the point of service should be 40 degrees Fahrenheit or less. RD G stated hair nets are required for all staff in the kitchen regardless of how much hair they have.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41994 Based on record review, observation, and interviews, the facility failed to properly prevent and/or contain the spread of Covid 19. The facility did not provide a private room for a resident readmitted from the hospital in TBP (transmission based precautions) for suspicion of COVID 19. Neither the resident readmitted , nor the resident already in the room were fully vaccinated. This had the potential to affect 19% of the 54 residents not vaccinated for COVID 19. Resident vaccination rate for the facility is 81% and staff vaccination rate is 83%. R20 was readmitted to the same room with a roommate within the facility after being hospitalized . R20 and roommate were not both fully vaccinated. This is evidenced by: The facility policy entitled Infection Control COVID-19 dated March 3/24/2020 states that residents who are suspected or confirmed to have COVID 19 for which additional precautions are needed to prevent infection transmission, the facility will ensure appropriate resident placement in a single resident space/private room if available. A facility document entitled All Staff-Reminders dated 6/8/2021 states as reminder number 13, If a resident has gone to the hospital and has now returned, if he is not fully vaccinated he will be placed on quarantine per CDC guidelines. If he previously had a roommate, they will be separated until quarantine is over (unless one or both of them has tested positive for COVID) The CDC document entitled, Updated Health Care Infection Prevention and Control Recommendations in response to COVID-19 vaccination. Updated on 4/27/2021. In this document the CDC defines fully vaccinated as being 2 weeks after the second dose in a 2 dose series, or 2 weeks after a single dose vaccine. If these requirements are not met, a person is not fully vaccinated. The guidelines further state that people should not engage in communal activities until they have met the requirements for discontinuation of Transmission Based Precautions. Example: R20 an [AGE] year old, was admitted back to the facility on [DATE] after being hospitalized for exacerbation of his CHF (Congestive Heart Failure). R20 was admitted back to previous room with a roommate R19. R20 was placed on TBP due to not being fully vaccinated and having been at the hospital. R20 was positive for COVID 19 on 12/22/20. R20 had both COVID19 vaccines, the second dose was given on 5/28/2021, therefore was not considered fully vaccinated. The CDC defines fully vaccinated as being 2 weeks after the second dose in a 2 dose series or 2 weeks after single does vaccine. R20's roommate, R19 had not been vaccinated. R19 tested positive for COVID 19 on 2/8/21. Throughout the survey, Surveyor observed R19 to be out and about the facility at will. R19 was wearing a mask but not always appropriately, sometimes under the nose. R19 was observed outside of the room several times during the day. R19 was also attending meals in the dining room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/10/2020 at 01:32 PM Surveyor observed R19 in the room with R20 without a mask. On 6/10/2021 Surveyor interviewed RN K and asked if it was routine to readmit a resident on TBP back into a room with a roommate? RN K stated, no, they usually go back to a private room. RN K was not sure why R20 went back to their old room. On 6/10/2021 Surveyor interviewed RN N regarding admitting a resident back from the hospital on TBP into a room with a roommate. RN N stated that usually they would go onto the Blue Hall after hospitalization as they have empty rooms. They would not have a roommate. RN N did not know why R20 was admitted back to the old room with a roommate. RN N stated they were aware that R19 was allowed to go about the facility. On 6/10/2021 at 9:45AM Surveyor interviewed the Director of Nursing (DON) regarding the expectations for R19, having a roommate that was in TBP. The DON stated that R19 is expected to wear a mask in the room, to wash hands frequently, and to keep the curtain pulled between the two beds. On 6/14/2021 at 7:42AM Surveyor interviewed the DON regarding Infection Control (IC) as DON is also the IC nurse. When asked why R20 was admitted back into a room with a roommate after having been in the hospital, the DON stated that it was a mistake and that they were not present in the facility at the time. When asked what is the standard of care for readmitting a resident back to the facility after a hospital stay the DON stated that if COVID 19 positive would be admitted to a private room. If roommate is positive also can return back with the roommate. If the person is in the hospital and negative COVID 19 the procedure would be to put in TBP for 14 days and no roommate. The DON was asked what fully vaccinated means regarding COVID 19. The DON stated that fully vaccinated meant that if the person got a one dose vaccine it would be two weeks after that shot, and if the person got a 2 dose vaccine it would be two weeks after the second dose. This is the CDC definition and the facility follows the CDC guidelines. The DON was asked if they were aware that R20 was not fully vaccinated and that R19 was not vaccinated at all, they replied that they were. The facility readmitted a resident under suspicion for COVID 19 on TBP and not fully vaccinated back into a room with a roommate who was not vaccinated. The roommate was allowed out of the room and free access to the facility. The facility did not follow CDC guidelines nor their own policy.