STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016083	A. BUILDING: _____ B. WING _____	R-C 01/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATHERWOOD (CBRF)	4510 GATEWAY DR EAU CLAIRE, WI 54701

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{N 000}	Initial Comments On 12/17/2025, Surveyor conducted a verification visit and 5 complaint investigations. On 12/22/2025, the Department received 1 additional complaint. Data collection continued through 01/05/2026. Three of 6 complaints were substantiated. Three of 4 deficiencies identified in Statement of Deficiency (SOD) CG1Q13, dated 07/02/2025 were corrected. Three deficiencies were identified. One of 3 deficiencies was a repeat deficiency. See SOD CG1Q13, dated 07/02/2025, and CG1Q12, dated 07/24/2024. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 7	{N 000}		
{N 220}	83.17(2)(a) Employees screened for communicable disease. The CBRF shall obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating all employees have been screened for clinically apparent communicable disease including tuberculosis. Screening for tuberculosis shall be conducted using centers for disease control and prevention standards. The screening and documentation shall be completed within 90 days before the start of employment. The CBRF shall keep screening documentation confidential, except the department shall have access to the screening documentation for verification purposes.	{N 220}		

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

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{N 220}	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 3 of 3 employees were screened for clinically apparent communicable disease, including tuberculosis (TB), within 90 days before the start of employment. This is a repeat deficiency and is being cited for the third time. See Statement of Deficiency (SOD) CG1Q13, dated 07/02/2025, and CG1Q12, dated 07/24/2024. Findings include: On 12/17/2025 at approximately 8:20 AM, Surveyor interviewed Administrator A and asked if new employees were screened for communicable disease, including TB. Administrator A stated Wellness Director (WD) B should have the documentation and was completing the screenings and administering the TB test. Surveyor asked Administrator A if WD B was a registered nurse (RN). Administrator A informed Surveyor WD B was not a nurse and did not have a professional license. On 12/17/2025, Surveyor requested to review three employee records. Caregiver C had a hire date of 10/10/2025. The record did not contain evidence Caregiver C had been screened for clinically apparent communicable disease, including TB. Caregiver D had a hire date of 10/27/2025. The record did not contain evidence Caregiver D had been screened for clinically apparent communicable disease, including TB.	{N 220}		

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{N 220}	Continued From page 2 Caregiver E had a hire date of 10/17/2025. The record did not contain evidence Caregiver D had been screened for clinically apparent communicable disease, including TB. On 12/19/2025 at 8:48 AM, WD B stated via email, "We do not have TB tests or communicable disease screenings for [Caregiver C], [Caregiver D] or [Caregiver E]. I will have those completed by the end of next week and can send them to you. I will get appointments scheduled at [clinic name] right away on Monday."	{N 220}		
N 416	83.37(2)(e) Other administration given or delegated by RN Other administration. Injectables, nebulizers, stomal and enteral medications, and medications, treatments or preparations delivered vaginally or rectally shall be administered by a registered nurse or by a licensed practical nurse within the scope of their license. Medication administration described under sub. (2)(e) may be delegated to non-licensed employees pursuant to s. N 6.03(3). This Rule is not met as evidenced by: Based record review and staff interview, the provider did not ensure 6 of 6 employees responsible for the administration of injectables were delegated by a registered nurse or a licensed practical nurse within the scope of the license. Medication administration described under sub. (2)(e) (Injectables, nebulizers, stomal and enteral medications, and medications, treatments or preparations delivered vaginally or rectally) were	N 416		

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not delegated to non-licensed employees pursuant to s.N6.03(3).

Findings include:

On 09/11/2025, the Department received a complaint regarding nurse delegation.

On 12/17/2025 at approximately 9:00 AM, Surveyor interviewed Administrator A and Wellness Director (WD) B and asked who the delegating nurse was. Administrator A stated they had a hospice nurse helping out, but did not have a contract with him/her. WD B stated s/he had been delegated by the hospice nurse to delegate to non-licensed staff for medications and tasks requiring nurse delegation. Surveyor asked WD B if s/he had a nursing license. WD B stated s/he did not have a license and was under the impression s/he could be delegated to delegate to others. WD B stated s/he was going to complete the delegation to all staff responsible for passing medications the following day at the monthly staff meeting. WD B informed Surveyor s/he could confirm Caregiver C and Caregiver D who were recently hired had not received delegation. WD B informed Surveyor all staff responsible for passing medications did not have a current delegation in place and would need to be re-delegated.

On 12/17/2025 at approximately 10:00 AM, Surveyor interviewed Caregiver D and asked if s/he was responsible for medication administration. Caregiver D stated s/he was the only caregiver working as the facility is staffed with one caregiver per shift, and was responsible for blood sugar checks in the morning and afternoon on first shift (6:00 AM-2:00 PM), and insulin at breakfast and lunch on first shift for

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Resident 1. Caregiver D identified Resident 2 was prescribed eye drops.

Surveyor asked Caregiver D if s/he had received nurse delegation to administer those medications and treatments. Caregiver D stated s/he was hired at the end of October and had not received delegation. Caregiver D was unable to identify if the provider had a nurse employed.

Surveyor reviewed the employee roster provided by Administrator A and asked WD B which staff were responsible for passing medications. WD B informed Surveyor the majority of staff were trained to pass medications, and listed the following employees: Caregiver C, Caregiver D, Caregiver E, Caregiver F, Caregiver G, and Caregiver H.

Surveyor requested to review a sample of 3 employee records.

Caregiver C had a hire date of 10/10/2025. The record did not contain evidence Caregiver C had been delegated to administer injectables.

Caregiver D had a hire date of 10/27/2025. The record did not contain evidence Caregiver D had been delegated to administer injectables.

Caregiver E had a hire date of 10/17/2025. The record did not contain evidence Caregiver E had been delegated to administer injectables.

Surveyor requested documentation of nurse delegation for the above employees from Administrator A and WD B. Documentation was not received.

Surveyor reviewed staff schedules received via

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N 416	Continued From page 5 email on 12/18/2025 at 4:11 PM. The schedule identified Caregiver C was scheduled as "Med Tech" to work first shift on 11/14/2025, 12/01/2025 and 12/12/2025. The schedule identified Caregiver E was scheduled as "Med Tech" to work first shift on 11/15/2025, 11/28/2025, 11/29/2025, and 12/02/2025. One staff was scheduled per shift. The provider did not ensure staff were delegated tasks by a licensed nurse pursuant to s. N 6.03(3) when the previous nurse left approximately 4 months ago.	N 416		
Y3244	50.09(1)(L) Care (1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to (l) Receive adequate and appropriate care within the capacity of the facility. This Rule is not met as evidenced by: Based on observation, record review and	Y3244		

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interview, the provider did not ensure Resident 1 received adequate and appropriate care when s/he experienced pain in his/her shoulder which resulted in decreased mobility related to transfers and ambulation status.

Findings include:

On 12/17/2025 at approximately 1:55 PM, Surveyor observed Caregiver G and Caregiver I transport Resident 1 via wheelchair to his/her room from the Residential Care Apartment Complex (RCAC) dining room. Upon entering Resident 1's room, Surveyor observed a Hoyer lift plugged into the wall of Resident 1's room. Caregiver G and Caregiver I placed Resident 1 next to a recliner chair and locked the wheelchair brakes. Caregiver G and Caregiver I stood on each side of Resident 1 [sic] and each placed an arm under Resident 1's armpit and grabbed a belt loop on the back of Resident 1's pants to assist Resident 1 to stand and pivot into the recliner. Resident 1 could not stand to pivot transfer, and Caregiver G and Caregiver I assisted Resident 1 back into a seated position. Resident 1 stated s/he was sorry and expressed s/he was tired to Caregiver G and Caregiver I. Caregiver G and Caregiver I attempted a second time to transfer Resident 1 into the recliner with no success. Resident 1 verbally expressed s/he wanted to lay down. Caregiver I unplugged the Hoyer from the wall and informed Surveyor the Hoyer was delivered the night prior but was not charged. Caregiver G and Caregiver I connected the Hoyer to the sling. While raising the Hoyer lift, the Hoyer battery died. Resident 1 remained in the wheelchair and was wheeled down the hallway to the living room where s/he fell asleep in the wheelchair in front of the television. At approximately 3:45 PM, Resident 1 was observed

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in the same spot.

Surveyor interviewed Caregiver G and Caregiver I during the observation about Resident 1's care needs. Caregiver G and Caregiver I stated it was the facility policy to operate the Hoyer lift with two staff at all times. Caregiver G informed Surveyor it took multiple staff members to transfer Resident 1 into bed the night prior.

On 12/17/2025 at approximately 2:00 PM, Surveyor reviewed Resident 1's individual service plan (ISP) received from Wellness Director (WD) B. The ISP read, in part:

-"Transferring - Hoyer lift: Resident is experiencing pain in [his/her] left shoulder. [S/he] will need to be transferred by a HOYER until the pain resolves. When [s/he] seems to be utilizing arm like normal, notify WD (wellness director) so [s/he] can assess and see if we can bump down transfer status back to [his/her] baseline. Schedule: Daily @ As Needed."

-"Transferring - Full assistance: Provide full assistance with transferring from bed to wheelchair/device, assist with pushing wheelchair/device. Schedule: Daily @ As Needed. Requires full assistance including moving from bed to wheelchair/device to open area's [sic] of facility/home. Utilize PRN hoyer [sic] for safety when weak."

On 12/17/2025 at approximately 2:45 PM, Surveyor reviewed staff charting notes for Resident 1. The following notes were reviewed:

"-12/12/2025 at 9:00 PM: Resident was extremely difficult to transfer this evening. Transfers required a hard 2 assist and at times a 3rd staff

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member present would have been effective. Resident rang to use the bathroom and voiced [sic] all 3 times within an hour span.

-12/13/2025 at 7:15 PM: Resident received and [sic] order for cefdinir 300mg 2x daily for the next 5 days for treatment for a UTI. This medication has been added to the MAR and will be delivered tonight.

-12/14/2025 at 6:45 PM: residents [sic] left arm is hurting. when [sic] doing range of motion, resident could only lift [his/her] left arm about half way [sic] up before [s/he] would say it hurt. [s/he] [sic] rated it a 5. [s/he] has a scheduled tramadol. 2 people got [him/her] ready for bed. hospice [sic] and wd (wellness director) was notified and a nurse will be out tomorrow to look at [his/her] arm [sic]

-12/15/2025 at 10:00 AM: WD was called last night in regards [sic] to limited mobility with pain. WD asked if [s/he] has [sic] a fall or if any incident occurred and staff answered no. WD told staff to administer a PRN Tramadol and call hospice to let them know that [s/he] was having arm pain with ROM. Hospice said that they will come tomorrow and assess [him/her]. They directed staff to call if anything changes... hospice and family decided to send [him/her] out to be evaluated. WD called ER at 7pm and found out that there were [sic] no finding [sic] and that they are sending [him/her] back. WD will update new orders (if any), when [s/he] reviews the care plan tomorrow.

-12/15/2025 at 11:00 AM: Resident has been complaining of shoulder pain since [s/he] woke up this morning. Resident rated [his/her] pain a 5. Resident was given [his/her] 8am medications

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which includes acetaminophen and tramadol for pain. About 45 minutes after taking medication, resident still rated [his/her] pain a 5 and said the pain in [his/her] shoulder has not gone away at all and resident could barely move it. Resident's hospice nurse came to check out what was going on. The nurse said it feels like [his/her] shoulder is dislocated so ordered a [sic] X-Ray to see if it is. Resident's hospice nurse talked with residents [sic] [son/daughter] about the option of discharging resident off of hospice so [s/he] can get [his/her] shoulder treated by a doctor and after that, resident could be admitted back onto hospice. Writer will update chart when further information comes. UPDATE: Resident was sent to the emergency room to get an X-Ray of [his/her] shoulder

-12/15/2025 at 9:45 PM: Resident is experiencing pain in [his/her] left shoulder. [S/he] will need to be transferred by a HOYER PRN until the pain resolves. When [s/he] seems to be utilizing arm like normal, notify WD so [s/he] can assess and see if we can bump down transfer status back to [his/her] baseline."

Resident 1 did not get adequate care and treatment when s/he experienced a change in condition which prompted the need for additional caregiver assistance for transfers. The facility had one staff scheduled and continued to schedule one staff after implementing an "as needed" (PRN) Hoyer mechanical lift for transfers in Resident 1's ISP. The Hoyer was not working [sic] and Resident 1 could not be transferred from wheelchair to recliner when requested on 12/17/2025.