STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525212	A. Building B. Wing	11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wisconsin Rapids Health Services	1350 River Run Dr Wisconsin Rapids, WI 54494

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 16692 Based on observation, interview and record review, the facility did not ensure each resident (R) was treated with dignity and respect and cared for in a manner that enhanced their quality of life for 2 residents (R16 and R24). Staff were observed feeding R16 and R24 part of their meals while standing over them. This was evidenced by: The facility policy titled The Dining Experience: Staff Responsibilities, dated 4/10/20, states in part: The dining experience will enhance each individual's quality of life through person centered dining. Example 1 R24 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease and anemia. R24's care plan states in part: Eating - assist with set up. Encourage and assist as needed to consume foods and/or supplements and fluids offered. On 10/22/24 at 8:39 AM, Surveyor observed R24 trying to eat her meal. R24 had been using a knife to eat with when Certified Nursing Assistant (CNA) F approached, gave R24 a spoon instead of a knife, and stated this might be easier. CNA F then stood over R24 and began feeding her. CNA F stood and fed R24 the rest of her meal. Example 2 R16 was admitted to the facility on [DATE] and had diagnoses including Parkinson's disease and legal blindness. R16's care plan states in part: Eating - independent after set up, uses a lip plate, Clock method to make aware of where food is, Assist of 1 as needed. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/22/24 at 12:36 PM, Surveyor observed CNA F feed R16 some bites of asparagus and an entire bowl of fruit while standing. On 10/24/24 at 11:07 AM, Surveyor interviewed Director of Nursing (DON) B. When Surveyor relayed the above observations to DON B, DON B stated, Staff should not do that; staff should be sitting when assisting residents with their meals.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31086 Based on observation, interview and record review, the facility did not ensure 2 of 4 residents (R) reviewed for pressure injuries (PI) (R151 and R32) received care consistent with professional standards of practice to prevent the development of a new pressure injury and promote healing of existing PIs. R151 was admitted to the facility with a sacral PI and was assessed to be at risk for PI development. R151 developed one unstageable PI on 10/16/24 and three unstageable PIs on 10/18/24. R151's care plan for PI interventions was not developed until 10/18/24 and not updated until 10/23/24 with interventions to off-load pressure areas to R151's bilateral lower extremities and sacral wound. The facility's failure to develop a care plan and implement interventions to off-load pressure to a resident's bilateral lower extremities and sacral wound created a finding of immediate jeopardy that began on 10/18/24. Nursing Home Administrator (NHA) A was notified of the immediate jeopardy on 10/28/24 at 3:30 PM. The immediate jeopardy was removed on 10/28/24; however, the deficient practice continues at a scope/severity level G (actual harm/isolated) as evidenced by the following example for R32. R32 had an existing stage IV pressure injury that developed 8.5 centimeters (cm) tunneling on the left hip and a stage IV pressure injury on the coccyx. R32 had wound vac therapy and multiple surgical debridements. The facility did not complete weekly pressure injury assessments, did not complete multiple treatments, and did not offload R32 as the care plan instructed. In addition, R32 missed wound clinic appointments on 8/14/24, 9/11/24, and 10/8/24. This is evidenced by: Guidelines from the National Pressure Injury Advisory Panel (NPIAP) Quick Reference Guide 2019 indicate in part: 2.1 Conduct a comprehensive skin and tissue assessment for all individuals at risk of pressure injuries: As soon as possible after admission/transfer to the health care service .5.1 Reposition all individuals with or at risk of pressure injuries on an individualized schedule, unless contraindicated .5.5 Reposition the individual in such a way that optimal offloading of all bony prominences and maximum redistribution of pressure is achieved .6.3 For individuals with a Category/Stage III or greater heel pressure injury, elevate the heels using a specifically designed heel suspension device offloading the heel completely in a way as to distribute the weight of the leg along the calf .NPIAP Classification Unstageable Pressure injury: Obscured full thickness skin and tissue loss. Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed . Example 1 (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R151 was admitted to the facility on [DATE] with diagnoses including multiple fractures of ribs, left side, chronic obstructive pulmonary disease (COPD), emphysema, anemia, hypo-osmolality and hyponatremia, atrial fibrillation, chronic kidney disease stage 3, anticoagulants, personal history of transient ischemic attack, atherosclerotic heart disease, peripheral vascular disease, congestive heart failure, prediabetes, and cardiac pacemaker. Hospital patient demographics, dated 10/10/24, documented an active wound on the posterior sacrum first assessed on 10/03/24 with the primary wound being a skin tear. An admission evaluation completed on 10/10/24 documented no skin impairments were present. The comments section documented, Bandage on lower back clean and dry. Bruising on (right) arm. Large Bruising noted to (left) hip area. Coban on (right) FA. R151's Admission Minimum Data Set (MDS) assessment, dated 10/16/24, documented a Brief Interview for Mental Status (BIMS) score of 12 which indicated R151 had moderately impaired cognition. The MDS documented R151 had impairment to both lower legs and required partial/moderate assistance of staff for toileting, and upper and lower body cares. The MDS documented R151 was at risk for pressure injuries and had 2 unstageable pressure injuries with slough and or eschar. The MDS indicated R151 did not have a turning or repositioning schedule and did not refuse cares. R151 was discharged home on 10/26/24. The facility completed a Braden scale pressure risk skin assessment on 10/11/24 with a score of 18 which indicated R151 was at risk. (The Braden scoring scale is: 15-18 at risk, 13-14 moderate risk, 10-12 high risk, 9 or below very high risk.) The facility completed a Braden assessment on 10/23/24 with a score of 20 which indicated R151 was not at risk. The facility did not develop a care plan addressing this risk until 10/18/24. A pressure injury weekly tracker, dated 10/13/24, documented an unstageable pressure injury on the left buttock that measured 3.5 cm x 4.5 cm with slough and light serosanguinous drainage. A physician order, dated 10/13/24, documented, Reposition every 2 hours and prn (as needed). The order did not mention offloading the buttock PI when repositioning R151. A wound clinic note, dated 10/16/24 at 9:56 AM, documented, Pressure sacrum unstageable due to necrosis, measuring 3.0 cm X 3.5 cm x 0.1 cm with moderate serous drainage. Pressure left lateral foot unstageable DTI (deep tissue injury) with intact skin undetermined thickness. Noted to be present on admission per staff. The PI measured 1.3 cm x 1.5 cm and the depth not measurable. Skin is intact with purple/maroon discoloration. Apply skin prep twice daily for 30 days. This is the first documentation of the wound. A Pressure Injury Weekly Tracker, dated 10/16/24 at 2:07 PM, indicated: Sacrum PI measured 3 cm x 3.5 cm x 0.1 cm, unstageable with necrotic tissue, 20% granulation tissue, 80% slough, 100% necrotic tissue, and had moderate serous drainage. On 10/16/24 at 2:30 PM, date acquired 10/16/24 in-house, R151's left lateral foot PI measured 1.3 cm x 1.5 cm unstageable with 100% necrotic tissue with no drainage, dark red or purple and/or non-blanchable. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R151 had the following physician orders: 10/16/24: Heel protectors to be on while in bed. 10/16/24: Air mattress needed for resident. 10/16/24: Wound type: Pressure wound. Location: left buttock/sacrum. Wound cleansing agent: normal saline or wound cleanser. Primary dressing type: Calcium alginate with silver, zinc to peri-wound. Cover dressing: Foam dressing. Frequency of dressing changes: Three times per week Monday-Wednesday-Friday and PRN. Expected duration of need: TBD (to be determined) one time a day every Mon, Wed, Fri for Wound Care and PRN AND as needed for if dressing is soiled or no longer intact. The facility ordered an alternating low air loss mattress on 10/16/24 which was placed on R151's bed on 10/17/24. On 10/16/24, the facility ordered liquid protein 30 milliliters (mls) two times per day. A Pressure Injury Weekly Tracker, dated 10/18/24, indicated: Left lateral foot (acquired on admission), unstageable PI measured 4.3 cm x 2.2 cm with 50% necrotic tissue with no drainage. The first PI weekly tracker assessment of the left lateral foot on 10/16/24 documented the PI was acquired in the facility. On 10/18/24, left plantar foot (acquired on admission), unstageable PI measured 2.2 cm x 1.7 cm, with necrotic tissue and no drainage. This is the first documentation of this PI. On 10/18/24, left heel (acquired admission), unstageable PI measured 1.6 cm x 0.7 cm with necrotic tissue and no drainage. This is the first documentation of this PI. On 10/18/24, right plantar foot (acquired on admission), unstageable PI measured 3.5 cm x 6.5 cm with necrotic tissue and no drainage. This is the first documentation of this PI. R151's care plan was first developed on 10/18/24 with the focus area: The resident has unstageable to heel and unstageable to sacrum pressure ulcer or potential for pressure ulcer development (related to) immobility. Interventions implemented on 10/18/24 included: Administer medications as ordered; Administer treatments as ordered; and Monitor for effectiveness. Interventions implemented on 10/23/24 included: Elevate bilateral lower extremities up on pillow to off load pressure area; Reposition to right side with pillow to off load sacral wound; Please chart refusals from resident; Follow facility policies/protocols for the prevention/treatment of skin breakdown. (The repositioning and heel interventions were added 13 days after R151's admission.) A physician order, dated 10/19/24, stated to apply skin prep to right plantar foot, left plantar foot, left heel, and left lateral foot for wound care two times a day. A nursing note, dated 10/19/24 at 10:00 PM, stated, Behavior Note: Note Text: Resident refused to be turned and repositioned on the evening shift. Went in at least every 2 hours but was in there more than that to ask him to be repositioned and he was refusing. Talked to him about the importance of being repositioned and he said that he already has a sore bottom so what is going to make the difference now. Explained to him that if he just stays in one position then the sore is going to get worse. He said for right now he does not want to be turned or repositioned. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R151's medical record did not contain a risk versus benefits statement for refusals of repositioning. R151's behavior monitoring charting indicated no refusals of cares and no documented behaviors. R151's nursing documentation did not indicate R151 refused care or treatments. On 10/21/24 at 11:22 AM, Surveyor interviewed R151's family member about his care. The family member stated R151 came into the facility with one PI on the butt and developed one PI on his foot. The facility changed R151's mattress, but the pillows are on the chair and staff don't elevate his heels. The wound doctor comes in to do the dressing. On 10/22/24 at 5:20 AM, Surveyor observed R151 in bed with his feet directly on the mattress and the pillows on his dresser. On 10/22/24 at 5:39 AM, Surveyor interviewed Registered Nurse (RN) P about R151's positioning and heel protectors. When Surveyor asked RN P to verify if heel protectors were on R151, RN P verified R151 did not have heel protectors on and there were none in the room. RN P checked R151's feet which were pressing on the foot board of the bed and directly on the mattress. When RN P asked R151 if he remembered if he had been wearing the heel boots, R151 said no. When RN P asked if R151 wanted a pillow under his legs, R151 willfully lifted his legs. RN P placed a pillow under R151's legs and stated she would get Certified Nursing Assistant (CNA) Q to assist with a boost. At 5:44 a.m., RN P and CNA Q boosted R151 so his feet were not touching the foot board. On 10/22/24 at 9:22 AM, Surveyor observed RN H provide wound care to R151's feet which were pressing on the foot board. RN H removed R151's socks and applied skin prep to the right foot plantar area, left foot plantar, lateral, and heel. Surveyor noted an area on the right foot that was small and dark with a callused area, the left lateral foot just below 5th digit was black and dry, the left plantar was small, dark, and callused, and the left heel had a small dark area. On 10/22/24 at 10:10 AM, Surveyor interviewed R151 about his feet pressing on the foot board and asked if staff elevated his heels with pillows or if he wore boots. R151 indicated staff have not put the pillows under his legs and the pillows are always sitting on the shelf. R151 indicated someone told him that he shouldn't wear the boots and his feet would heal better without them. R151 could not remember who told him. R151 stated his feet didn't hurt but they press on the foot board when the head of the bed is up and he slides down in bed. Staff boost R151 up when asked. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 10/23/24 at 1:15 PM, Surveyor observed RN M remove Mepilex from R151's buttock. The area had 100% slough and a red peri-wound. RN M stated the area was unstageable with 100% slough. The area measured 2.9 cm x 3.2 cm. RN M assessed R151's left lateral foot below the 5th digit on the pad of the foot and measured 1.8 cm x 1.3 cm. The area appeared dark in color and dry with no raised area or appearance of being open. RN M measured the left foot plantar area to be 2 cm x 1.8 cm. Surveyor observed a small red DTI area with hard skin. RN M measured the left heel to be 0.6 cm x 1.3 cm. Surveyor observed a small red DTI area with hard skin. RN M measured the right foot plantar area to be 3.0 cm x 3.0 cm. Surveyor observed a small red DTI area with hard skin. RN M indicated all the areas were unstageable. RN M looked for boots for R151. When RN M asked if he had been wearing the boots, R151 stated no. Surveyor told RN M that Surveyor observed boots in R151's closet on the top shelf. When RN M got the boots, R151 refused. When RN M asked why R151 didn't want the boots and if they were hot, R151 stated he could not remember who told him that he would be better off not wearing the boots. RN M educated R151 that wearing the boots would help his feet from hitting the foot board and causing more issues. R151 agreed to wear the boots. RN M applied the boots and placed a pillow under R151's calves. On 10/23/24 at 1:40 PM, Surveyor interviewed RN M about R151's documentation of PIs and asked if the PIs were facility-acquired. RN M indicated that she was not sure if the PIs were facility-acquired and thought the PIs were initially assessed upon admission. Surveyor stated the left lateral foot was initially noted to be facility-acquired but the assessments after that documented the PIs were present upon admission. RN M indicated she wasn't sure when she did the assessment so she marked the wounds as present upon admission. RN M indicated she would change the assessments to indicate the PIs were facility-acquired. On 10/24/24 at 8:24 AM, Surveyor interviewed Director of Nursing (DON) B and asked if R151's PIs were avoidable or unavoidable. DON B indicated all PIs are avoidable. On 10/28/24 at 11:57 AM, Surveyor interviewed RN O (the facility's MDS Coordinator) about R151's 10/16/24 Admission MDS assessment that coded 2 PIs on admission. RN O indicated the coding was based on information in the chart from admission and the wound clinic note. Surveyor and RN O reviewed the facility's admission evaluation documentation that indicated R151 did not have any skin impairments. There was a PI weekly tracker completed on 10/13/24 of the left buttock and a non-pressure injury to the right buttock. On 10/16/24, the PI weekly tracker assessments stated a sacrum PI and left lateral foot PI were acquired on 10/16/24 in house. A hospital demographics note on 10/10/24 documented the sacrum but did not document the left lateral foot. RN O indicated the wound clinic note documented the left lateral foot was present upon admission. Surveyor stated the wound note documented noted to be present on admission per staff but there was no documentation that staff assessed a left lateral foot PI until 10/16/24 after the wound clinic evaluation. RN O indicated she understood and stated the MDS should have been coded with 1 PI to the sacrum on admission and 1 PI to the left lateral foot facility-acquired and indicated the MDS would be updated. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 10/28/24 at 12:46 PM, Surveyor interviewed Nurse Practitioner (NP) N about R151 having PIs on admission. NP N reviewed R151's admission notes and did not see any documentation of R151 having PIs on his feet. NP N indicated she would have reviewed the hospital discharge note and would follow-up with R151 when next seen. NP N reviewed the hospital discharge note and noted there were no PIs on R151's feet and the only skin area noted was the sacrum. NP N indicated she should be notified by the facility if there was a change in condition and expected to be notified of the start of a PI. NP N reviewed her communication with the facility and dictation and stated there was no documentation of R151 having any PIs. NP N indicated she was not aware that R151 had any PIs on his feet. NP N indicated she would have reviewed the wound clinic orders, ensured the facility was following the orders, and would have assessed R151 on her next visit. NP N indicated the only time R151 refused care was related to the use of oxygen upon discharge. NP N indicated R151 told her everything was fine and he had no pain or concerns. The failure to initiate a care plan and implement interventions to prevent pressure injuries resulted in serious harm for R151 and led to a finding of immediate jeopardy. The facility removed the jeopardy on 10/28/24 when it completed the following: 1. Completed wound assessments for residents with pressure injuries and skin assessments for all in-house residents. 2. Updated care plans with pressure prevention interventions. 3. Educated licensed nursing staff on the facility's policy, assessing residents upon admission, implementing pressure injury prevention interventions, implementing treatment orders, documentation, and provider notification. 4. Educated nursing and therapy staff on implementing pressure injury prevention interventions. 5. Implemented audits to ensure compliance. 40590 Example 2 R32 had diagnoses including fracture of left pubis (admission diagnosis), moderate protein calorie malnutrition, and diabetes mellitus type 2. R32's MDS assessment, dated 9/5/24, indicated R32 had no behaviors or rejection of care and had two stage 4 unhealed pressure injuries. R32 had a BIMS score of 14 which indicated R32 was cognitively intact; however, R32 was a poor historian. R32's care plan, initiated 4/11/24, indicated R32 had potential/actual impairment to skin integrity and was at high-risk due to multiple open wounds (revised 10/22/24). Care plan interventions on admission included: The resident will maintain or develop clean and intact skin by the review date; Keep skin clean and dry. Use lotion on dry skin as ordered/desired/needed; Meds/labs/treatments as ordered. An active physician order with a start date of 5/23/24 stated, Reposition every hour, document refusals, three time a day for repositioning. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A Braden Scale assessment, dated 9/1/24, had a score of 12.0 which indicated R32 was at high risk for pressure injuries. R32 had wound care to be done every Monday and Friday by the facility and every Wednesday in the wound clinic. On 7/24/24, R32 was noted to have stage 4 pressure injuries on the coccyx/sacrum and left trochanter/hip. A facility Pressure Injury Weekly Tracker showed: Sacrum 2.4 x 1.4 x 4.2 stage 4, necrotic Left hip: No wound measurements on assessment by the facility Wound Clinic (WC) measurements indicated: Coccyx: 2.4 x 1.4 x 4.2, foul odor, exposed bone and muscle, stage 4 Left hip: 4.0 x 3.7 x 5.1, with tunnel, stage 4 (there was no measurement of the tunnel) WC treatment orders indicated: Wash with Dakin's 0.25% solution. Skin prep to peri-wounds. Bridge wound vac to cover both wounds. Wound vac set to -125 mmHg (millimeters of mercury). To be changed Monday and Friday at the nursing home and Wednesdays in the wound clinic. A WC physician note indicated: No wound vac was applied or came with the patient today. We will do a dakin's wet to dry covered with 4x4 Allevyn in clinic but Nursing Home, please get the wound vac applied today. R32's Treatment Administration Record (TAR) indicated: Wet to dry dressing with normal saline and Kerlix. Skin prep around wound to protect healthy skin and cover with foam adherent dressing. To be completed TID (three times daily) and as needed until wound vac supplies arrive. The treatment was not signed out on 7/22 noon, 7/23 PM, or 7/24 PM. R32's medical record did not indicate the WC physician was updated that R32's wound vac was removed. On 7/31/24, a Pressure Injury Weekly Tracker indicated: Sacrum: 2.2 x 1.4 x 2.5 stage 4, granulation Left hip: 3.2 x 3.2 x 6.3 stage 4, granulation (increased depth of left hip) There were no new interventions on R32's care plan. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	WC treatment orders indicated: Wound vac-wash with Dakin's 0.25% solution. Apply vacuum-assisted closure device at -125 mmHg. With green foam to left hip and coccyx (note change in treatment to green foam). With bridge dressing to cover both wounds. Apply skin prep to peri-wound and transparent semi-permeable cover dressing. One time a day every Monday, Wednesday, Friday for wound care. Wound clinic to change wound vac on Wednesdays. On 8/7/24, WC measurements indicated: Coccyx: 2.2 x 1.9 x 2.8, with foul odor Left hip: 3.3 x 3.4 x 3.5, with tunnel 8.0 cm A nurses note, dated 8/11/24 at 5:40 PM, stated, Resident refused repositioning at 1600 (4:00 PM); agreed to lift up on arms to give buttocks a break from sitting but refused to lay down and get off buttocks. This was the first documented refusal by R32 since admission on 4/11/24. There were no facility weekly wound assessments with measurements or wound clinic notes in R32's record for 8/14/24. R32 was supposed to have a wound clinic appointment on 8/14/24. A Nursing Skin/Wound Note, dated 8/15/24, stated, Note Text: wound care completed by wound care nurse. Wound vac dressing to hip and coccyx changed. Measurements taken. Coccyx measures 2.3 cm x 3.5 cm x 2.0 cm. Left hip measures 3.1 cm x 3.1 cm x 8.4 cm. (increased depth) On 8/21/24, a Pressure Injury Weekly Tracker indicated: Sacrum: 2.2 x 1.9 x 2.8 stage 4, granulation Left hip: 3.3 x 6.4 x 3.5 stage 4, granulation, necrotic fat, necrotic muscle, debrided, with tunnel at 11:00, strong odor (increased width) WC measurements indicated: Coccyx: 1.8 x 1.3 x 2.5 with foul odor Left hip: 2.5 x 2.6 x 3.5 with tunnel 6 cm (Inconsistent measurements from wound clinic compared to facility weekly PI tracker) A WC treatment order on 8/21/24 indicated: Wash with Dakin's 0.25% solution. Skin prep peri-wounds. Apply Puracol collagen to the base of the wounds (whole pack to each wound). [NAME] foam to areas that are visible. Black foam on top of white foam (foams must be touching within the wound). Bridge vac to cover both wounds. Wound vac set to -125 mmHg. To be changed Monday and Friday at the nursing home and Wednesdays in the wound clinic. The wound care treatment was changed on 8/21/24 when the wound increased in size. Puracol collagen was added. (continued on next page)

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	525212	A. Building B. Wing	11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wisconsin Rapids Health Services	1350 River Run Dr Wisconsin Rapids, WI 54494

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R32's treatment was not signed out on 8/23/24. A Nursing Skin/Wound Note, dated 8/25/24,stated, Note Text: Wound vac alarming with a leak alert. Wound vac removed and wounds to right hip and coccyx packed with dakins soaked gauze and to be changed BID (twice daily). Wound vac canisters ordered. There was no evidence the wound physician was updated. On 8/28/24, Pressure Injury Weekly Tracker measurements were the same as the wound clinic and indicated: Coccyx: 2.2 x 1.6 x 2.5 foul odor Left hip: 2.7 x 2.7 x 3.5 with tunnel 8.5 cm The wound care treatment order was the same as 8/21/24. R32's TAR indicated: Pack coccyx and right hip wounds with Kerlix damp with quarter strength Dakin's BID until wound vac is able to be put back on. The treatment was not signed out on the 8/30 PM shift and the order identified the wrong hip. A Nursing Skin/Wound Note, dated 8/29/24, stated, Note Text: Wound care completed by wound care nurse. Wound Vac not on, waiting on white foam, wet to dry applied. A Nursing Skin/Wound Note, dated 8/31/24, stated, Note Text: Wound care completed by this writer. Wound Vac applied. On 9/4/24, a Pressure Injury Weekly Tracker indicated: Sacrum 2.4 x 2.1 x 2.5 stage 4, granulation Left hip: 2.3 x 2.4 x 6.0 stage 4, undermined 6 cm (improved) A WC physician note indicated: Left hip with undermining has a 6 cm tunnel going cranially. The ulcer is stage 4 with necrotic muscle, necrotic fat, necrotic connective tissue. The coccygeal ulcer has some necrotic muscle, necrotic fat present but improved and does not probe to bone but only muscle. A Wound Debridement physician note indicated: Wound debridement to remove necrotic fat, necrotic muscle, necrotic connective tissue, tenacious yellowish slough, necrotic fascia, and fibrin from base of coccyx and left ischium wound. Coccyx pre-debridement measurement: 2.4 x 2.1 x 2.5 with foul odor Left hip pre-debridement measurement: 2.3 x 2.4 x 6.0 with tunnel. WC measurements post debridement indicated: (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Coccyx: 2.1 x 1.9 x 2.5 stage 4 with foul odor Left hip: 2.1 x 2.1 x 9.0 with tunnel The WC treatment order was the same as 8/21/24. R32's treatment was not signed out on 9/2, 9/6, 9/11, or 9/16. A nurses note, dated 9/7/24 at 5:08 AM, stated, Resident refused to be toileted or repositioned on last rounds. This was the second documented refusal and last documented refusal R32's medical record. On 9/11/24, there were no weekly in-house wound assessments or at the wound clinic. On 9/18/24, a Pressure Injury Weekly Tracker indicated: Sacrum 2.1 x 1.9 x 2.5 stage 4 Left hip: 2.1 x 2.1 x 9.0 stage 4, granulation with foul odor, tunnel 9 cm deep R32's treatment was not signed out on 9/20, 9/23, or 9/25. On 9/25/24, a Pressure Injury Weekly Tracker showed same measurements as the wound clinic: Coccyx: 2.1 x 1.9 x 2.0 with foul odor (improved) Left hip: 1.9 x 2.0 x 9.0 with tunnel (improved) On 9/30/24, a Pressure Injury Weekly Tracker indicated: Sacrum 1.0 x 0.9 x 3.0 stage 4, granulation 34-66%, necrotic 34-66% Left hip: 1.2 x 1.5 x 9.0 stage 4, granulation tissue 34-66%, necrotic tissue 34-66% WC measurements indicated: Coccyx: 1.0 x 0.9 x 3.0 with foul odor (improved length x width) Left hip: 1.2 x 1.5 x 9.0 with tunnel (improved length x width) A WC treatment order indicated: Left hip wound vac is on hold for left hip 9/25/24. Wash with Dakin's 0.25% solution. Pack with gauze soaked in Dakin's 0.25% solution (wring out so it's damp but not dripping). Apply 6 x 6 Allevyn or similar dressing over the wound. Clean and change dressing daily. On 10/2/24, WC measurements indicated: Coccyx: 1.1 x 1.2 x 2.5 with foul odor (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Left hip: 3.6 x 3.1 x 4.0 with 7.5 cm tunnel R32's treatment was not signed out on 10/3, 10/5, 10/9, or 10/10. On 10/9/24, there was no in-house weekly wound assessment or wound clinic note in R32's medical record. R32 was supposed to have a wound clinic appointment on 10/9/24. On 10/16/24, WC measurements indicated: Coccyx: 0.9 x 0.6 x 1.5 foul odor (improved) Left hip: 2.2 x 2.1 x 3.2 with tunnel 6.0 cm (improved) A WC physician note indicated: Continue wound vac for both wounds but the hip ulcer may have to be opened up further. On 10/22/24, DON B was made aware that Surveyor wanted to observe R32's dressing change on 10/23/24. DON B stated the dressing change would not done in-house on 10/23/24 because R32 had a wound clinic appointment. On 10/23/24, WC measurements indicated: Coccyx: 0.7 x 0.8 x 2.0 foul odor Left hip: 3.1 x 1.9 x 3.5 with tunnel 6.5 cm A WC Surgical Debridement note indicated: Sacrum: Necrotic muscle, necrotic fat, necrotic connective tissue, tenacious yellowish slough, necrotic fascia, and fibrin from the base of the wound removed. Left Hip: Necrotic muscle, necrotic fat, necrotic connective tissue, yellowish slough, and fibrin from the base of the wound removed. Has tunneling at 7.5 cm deep. Left hip measurement pre-debridement: 3.1 x 1.9 x 3.5 Coccyx measurement pre-debridement: 0.7 x 0.8 x 2.0 A WC treatment order indicated staff should continue the same left hip/coccyx treatment. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 10/22/24 at 7:03 AM, Surveyor observed R32 in bed asleep. R32 was positioned on the right side facing the doorway. At 7:37 AM, Surveyor observed Certified Nursing Assistant (CNA) L exit R32's room with R32 in a wheelchair and take R32 to the dining area for breakfast. At 7:42 AM, Surveyor observed R32 in the dining room eating breakfast independently. At 8:05 AM, Surveyor observed staff take R32 to therapy. At 9:10 AM, R32 returned from therapy. At 9:16 AM, Surveyor observed CNA L enter R32's room and ask if she needed anything. R32 stated she needed to go to the bathroom. CNA L retrieved gloves from a bin in the hallway. At 9:18 AM, Surveyor observed CNA L exit R32's room and don personal protective equipment (PPE) in the hallway. R32 was not repositioned during those 2 minutes. At 9:21 AM, Surveyor observed CNA L state to R32, I will come back for you and exit R32's room. At 9:44 AM, Surveyor observed staff take R32 to a resident council meeting. At 11:00 AM, Surveyor observed R32 in a wheelchair watching TV in her room. At 11:15 AM, Surveyor observed a CNA take R32 to the dining room. At 12:19 PM, Surveyor observed a CNA take R32 back to her room. Surveyor observed R32 in her wheelchair watching TV from 12:20 PM to 2:45 PM and noted R32 was sitting in her chair from 7:37 AM until she was last observed at 2:45 PM which was approximately 7 hours. An observation of R32's wheelchair cushion on 10/24/24 at 6:49 AM indicated R32 did not have a pressure reducing cushion. The cushion was labeled Comfort Curve. Key specs of Comfort Curve cushion use state, Your Risk of Skin Breakdown: Low. The cushion was not a pressure relieving cushion for the prevention of or promotion of healing pressure injuries. On 10/24/24 at 7:55 AM, Surveyor interviewed R32 regarding wound care and repositioning. R32 stated, The wound is on my butt, and they are changing the bandages on my butt. R32 also stated, They change the bandage on Wednesday, and they use a ruler to take measurements. When asked if staff educated R32 on the risks and benefits of repositioning, R32 stated, Yes. R32 had a poor memory and could not distinguish between facility and wound clinic staff regarding measurements and dressing changes. R32 also could not recall how staff repositioned her in bed or how often. On 10/24/24 at 8:05 AM, Surveyor interviewed CNA L and CNA K regarding R32's wound care and repositioning. CNA L stated, We wash her up. We lotion her and reposition her every 2 hours. CNA K stated, We wash her and lotion her skin, do skin inspections on her bottom to make sure she doesn't have pressure sores. We reposition her from her left side to her right side and keep her dry. On 10/28/24 at 3:35 PM, Surveyor interviewed DON B and Assistant Director of Nursing (ADON) J regarding R32's wound care and assessments. Surveyor shared concerns that the facility's PI measurements were identical to the wound clinic's measurements each week. ADON J stated the facility used the wound clinic physician's wound assessments and measurements for their weekly wound assessments and indicated they had not been doing their own weekly PI assessments on Mondays or Fridays with dressing changes. (continued on next page)

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