STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525695	A. Building B. Wing	11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Anna John Resident Centered Care Community	2901 South Overland Road Oneida, WI 54155

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43361 Based on staff interview and record review, the facility did not ensure the appropriate care and treatment was provided for 1 resident (R) (R10) of 2 residents reviewed for skin integrity. R10 was admitted to the facility with a venous stasis ulcer on the right great toe and was seen by the wound clinic and vascular surgeon. The facility did not complete weekly wound assessments or notify R10's physician timely when changes were noted in the wound. Findings include: The facility's undated Management of Wounds policy indicates: .4. The wound nurse will monitor all pressure, non-healing wounds, complicated surgical wounds, and any other wounds directed to be monitored by the wound care team or primary care provider (PCP) weekly and consult with the PCP as needed for changes in treatment or updates in changes in the condition of the wound .8. A care plan will be developed for the wound and updated with changes as needed based on resident preferences of treatment and care, this will be maintained in the electronic health record. The facility's Notification of Change of Condition policy, revised on 12/21/21, indicates: Physicians, the Director of Nursing (DON), and responsible family members or legal representatives shall be notified as soon as possible within 24 hours of any changes in the resident's condition based on the acuity. From 11/4/24 to 11/6/24, Surveyor reviewed R10's medical record. R10 was admitted to the facility on [DATE] and had diagnoses including peripheral vascular disease (PVD), type 2 diabetes mellitus with diabetic chronic kidney disease, and presence of cardiac and vascular implant and graft. R10's Admission Minimum Data Set (MDS) assessment, dated 4/3/24, indicated R10 had one venous stasis/arterial ulcer present. R10's most recent Minimum Data Set (MDS) assessment, dated 8/29/24, had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated R10 was not cognitively impaired. R10 was R10's own decision maker. R10's medical history indicated R10 had a stint placed in R10's leg approximately [AGE] years prior and had not done much follow-up with the stint since then. An initial admission skin assessment, dated 3/26/24, indicated R10 had a diabetic ulcer on the right great toe with black eschar (dead tissue) with no odor. (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An assessment completed by DON-B, dated 3/27/24, indicated R10 had a venous/arterial ulcer on the right great toe (lateral edge under the nail) that was present upon admission. DON-B was unable to stage the wound due to eschar. The wound bed was dark purple with no drainage. The surrounding tissue was pink and tender to palpation. The area around the edge of wound contained cracked tissue. The wound measured 6.6 centimeters (cm) (length) x 2.2 cm (width) x 3.0 cm (depth) and had necrotic tissue (non-viable tissue due to reduced blood supply). The facility contacted R10's physician on 3/27/24 and indicated R10 appeared to have an arterial ulcer due to the foot pallor (a condition where the skin appears paler than normal), temperature (cool to touch), and no hair on the toe with 100% eschar and tenderness. R10 was willing to be seen by the wound clinic to rule out osteomyelitis. Staff requested R10's toenails be trimmed and indicated R10 needed to see podiatry because R10's toes appeared to have onychomycosis (nail fungus). The facility received wound clinic and podiatry referrals from R10's physician on 3/28/24. A wound clinic note, dated 4/3/24, indicated R10 had a history of diabetes, Hodgkin's and non-Hodgkin's lymphoma, and stroke. R10 was admitted to the hospital on 2/23/24 for renal failure hyperkalemia, hypertension, and anemia related to chemotherapy. Hospice care was discussed but put on hold. R10 had a wound on the distal tip of the right great toe and was not sure how long the wound was present. Dopplerable pulses were weak. The wound measured 2.5 cm x 2.8 cm x .05 cm depth. The note indicated the wound was a pressure injury on the distal right great toe that was unstageable due to non-viable tissue obstructing the wound bed. Recommendations included Betadine daily dressing changes and to follow-up with the vascular surgeon in 2 weeks. The facility initiated an order to apply Betadine and a dry sterile dressing to the right great toe on 4/3/24. A weekly skin observation completed by Registered Nurse (RN-C) on 4/3/24 indicated R10 had ischemic insufficiency on the right great toe with necrotic tissue and pain with palpation. Staff notified R10's physician on 4/22/24 that R10 had a calloused, reddened area on the left second toe that measured 1 cm x .5 cm and was painful to touch and when R10 wore socks. No open area was noted. The physician ordered a Band-Aid to the toe. R10 saw a vascular surgeon on 4/24/24 and was scheduled for an ultrasound on 4/30/24. The facility notified the wound clinic on 4/29/24 that R10's right heel was boggy and tender. R10 had a specialty mattress with heel boots. R10 also had right second toe skin shear and a left second toe scab at the metatarsal head with tenderness. An order was initiated to apply Betadine to the left second toe daily and wear heel boots when resting. The Band-Aid to the left toe was discontinued. A vascular ultrasound, dated 4/30/24, indicated the technologist could not palpate the dorsalis pedis on either side. The findings were consistent with severe stenosis (above 70%) in the distal SFA, the proximal popliteal artery, and the proximal posterior tibial artery, multi-focal moderate stenosis of the anterior tibial artery, and occlusion in the distal peroneal artery with poor blood flow in both feet. A right lower extremity angiogram (a medical imaging technique that visualizes blood vessels and blood flow) was scheduled for 5/20/24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff notified R10's facility physician on 5/2/24 that R10 had increased pain in the right great toe and heel related to worsening vascular status and spreading necrotic tissue. R10 took as needed (PRN) Tylenol which was not effective. The physician ordered skin prep to the heel and prescribed tramadol (used to treat moderate to severe pain). A general skin observation note, dated 5/4/24, indicated the tip of R10's right great toe was black with hardened tissue and had increased in size since the last assessment on 4/21/24. Progress notes, dated 5/5/24, indicated R10 reported pain after a wound treatment and was offered interventions for pain management. R10's right great toe was darker in color than the day before and was deep red/purple at the base and black/dark purple at the tip. R10 complained of pain in the heel which was boggy. Skin prep was applied. R10 refused heel boots and was educated. R10 allowed the writer to elevate R10's heels on a pillow while in the recliner. A wound clinic note, dated 5/6/24, indicated R10 complained of pain in the toe and plantar heel likely due to early signs of infection. Antibiotic therapy was prescribed. R10's right great toe was demarcating (boundary between living and dead tissue) with increased redness to the foot. R10 was advised if R10 had increased redness, fever, chills, nausea, vomiting, shortness of breath, or chest pain, R10 should go to the Emergency Department (ED) immediately. The writer was concerned R10 might lose more than a toe consistent with possible TMA (transmetatarsal amputation) versus BKA (below the knee amputation). Recommendations included Betadine daily dressing changes and follow-up in 2 weeks. A progress note, dated 5/11/24, indicated R10's right great toe and second toe were black in color. R10's right second toe contained a scab. R10's left second toe contained a scab and a callous. A progress note, dated 5/12/24, indicated Betadine was applied to blackened necrotic tissue on R10's right great toe, an area medial to the base of the toe, the top of the right foot, and a medial scabbed area on the left great toe. R10 declined tubigrips and heel boots. A progress note, dated 5/13/24, indicated R10's right great toe and second were black and discoloration had spread to the top of the foot. A progress note, dated 5/14/24, indicated R10's right great toe was entirely black/purple in color with discoloration on the top of the foot. The skin was firm. R10 winced with Betadine and PRN medication offer and declined prior to and during treatment. R10's dressing was changed as ordered. A progress note, dated 5/16/24, indicated the writer left a message for the wound doctor regarding the condition of R10's right great toe. The wound doctor's representative was informed that R10's right second toe and top of the foot contained black necrotic tissue. R10 was send to the ED and admitted to the hospital. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A wound physician consult note, dated 5/18/24, indicated R10 was admitted to the hospital on 5/16/24 for critical limb ischemia. The only blood flow to R10's right foot was the posterior tibial artery which supplied blood flow to the bottom of the foot. There was little to no flow to the dorsal foot. The wound and vascular surgeons consulted about the possible failure of a TMA. R10 was counseled on treatment options. A possible TMA was discussed with the hope the incision would heal and R10 could function with diabetic shoes and toe filler; however, due to the lack of circulation to the top of the foot, there was a great chance of failure and R10 would then would require a BKA. The goal of surgery was to save the foot, however, R10 would still be at risk of losing the foot if the surgery failed or there were complications with healing. R10 opted to proceed with a BKA. An initial skin assessment upon R10's return from the hospital indicated R10 had a dried scab on the tip of R10's left great toe. An order was initiated to apply Betadine daily. No concerns were noted with documentation or treatments during that time. The facility's wound nurse contacted the wound clinic on 7/2/24 and scheduled an appointment for R10's left toe scab on 7/17/24. Daily Betadine treatments continued between 7/2/24 and 7/17/24 with no concerns noted until 7/15/24. A progress note, dated 7/15/24, indicated Betadine was applied to the scab on R10's left great toe. R10 indicated discomfort with touch. The note indicated the nurse would update the Interdisciplinary Team (IDT). A progress note, dated 7/16/24, indicated Betadine was applied to the scab on R10's left great toe. R10 indicated discomfort with touch. R10 was scheduled to see the wound clinic on 7/17/24. During a wound clinic visit on 7/17/24, the physician was concerned about the possibility of infection since R10 complained of pain the last few days and started R10 on an antibiotic. Betadine to the left toe daily was continued. R10 was seen by the wound clinic and followed by in-house weekly wound care since 7/17/24. R10's in-house weekly wound care assessments did not include measurements of the right great toe between 4/8/24 and 5/13/24, however, staff who completed the treatments documented daily observations of the wound. Surveyor also noted between 5/23/24 (when an area on R10's left toe was noted upon readmission) and 7/17/24, in-house weekly wound assessments with measurements were not completed, however, licensed staff charted daily on R10's left great toe when treatments were completed. Staff noted observations and any concerns with infection. As previously noted, R10 saw the wound clinic on 5/6/24 and was started on an antibiotic due to the possibility of infection. R10's progress noted indicated staff observed more changes in R10's toe(s) beginning on 5/11/24 but did not contact the physician until 5/16/24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/07/24 at 10:50 AM, Surveyor called the wound clinic and spoke with Registered Nurse (RN)-D who indicated R10 was seen on 5/6/24 and was started on antibiotic therapy for a possible infection. RN-D indicated R10's second toe had a little discoloration on 5/6/24 but the great toe was concerning. RN-D indicated the wound doctor was already concerned with infection and the possibility that R10 would lose the toe or more. RN-D indicated R10 had severe blood flow issues and had appointments scheduled for vascular issues, including an angiogram on 5/20/24. RN-D reviewed a wound assessment from when R10 was admitted to the hospital on 5/16/24 and indicated (based on photos) that R10 was losing at least the right great toe and possibly the second toe. When Surveyor indicated staff noted changes in R10's foot on 5/11/24 but did not contact the wound clinic until 5/16/24, RN-D could not say if earlier notification would have made a difference, but indicated they would have wanted to know as early as possible. RN-D indicated if staff would have called earlier, they likely would have been instructed staff to send R10 to the ED which was the fastest way to get assessed. RN-D indicated the wound clinic's records did not contain a call from the facility to the triage nurse before 5/16/24. RN-D indicated R10's vascular surgeon would be back on 11/11/24 and would contact Surveyor if the surgeon felt that contacting the wound clinic on 5/11/24 (when the changes were noted) would have made a difference in the outcome. Surveyor did not receive a return phone call. On 11/6/24 at 10:17 AM, Surveyor interviewed DON-B who indicated DON-B completed R10's initial wound assessment. DON-B indicated shortly after R10 was admitted to the facility, DON-B was off work for awhile and Assistant Director of Nursing (ADON)-E and RN-C completed wound care during that period. DON-B indicated RN-C was wound care certified as of 4/24/24, but was training and following wound care at the facility prior to that time. DON-B reviewed R10's medical record and verified weekly wound care assessments/measurements for R10 were not completed. DON-B indicated weekly wound notes should be completed by the in-house wound care team. In a follow-up interview, DON-B confirmed the in-house wound care team should complete in-house assessments even if a resident was seen by the wound clinic. DON-B confirmed wound notes for R10's left toe should have been completed upon R10's return from the hospital on 5/23/24. DON-B and Surveyor reviewed the progress notes where staff noted changes to R10's foot on 5/11/24 but didn't contact the physician until 5/16/24. DON-B indicated staff should have contacted the physician when there were changes. On 11/6/24 at 10:53 AM, Surveyor interviewed ADON-E who reviewed R10's medical record and verified R10's weekly in-house wound notes did not include measurements for the right and left toes. ADON-E also verified staff did not contact the physician timely when changes that were noted on 5/11/24 and indicated it is staffs' responsibility to contact the physician if they note changes. ADON-E indicated staff should also contact the wound nurse if there are changes. ADON-E confirmed weekly in-house wound notes should be completed for all wounds.