STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525330	A. Building B. Wing	08/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Middleton Village Nursing and Rehab	6201 Elmwood Ave Middleton, WI 53562

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36253 Based on observation, interview, and record review, the facility did not ensure a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 1 of 17 residents observed for activities of daily living (R3). R3 appeared disheveled and did not have his hair washed. Findings include R3 was admitted to the facility on [DATE]. The facility lists R3 diagnoses to include morbid obesity and need for assistance with personal care. His most recent Minimum Data Set (MDS), dated [DATE], states he needs physical assistance of 2 or more staff for bed mobility and transfers. This MDS also states R3 requires one person assist for personal hygiene and totally dependent on staff for bathing. On 8/16/22 at 12:52 PM, Surveyor observed R3 in bed. R3 appeared disheveled. His hair appeared greasy, uncombed and had clumps of skin throughout. When asked if the facility provides regular showers, R3 stated they often do bed baths and did one the previous day (8/15/22), but it was very brief, and they did not wash his hair. R3 stated he would like his hair shampooed as it had not been washed or cleaned for at least a couple weeks. Facility documentation shows R3 was provided a bed bath on 8/15/22. On 8/16/22 at 4:10 PM, Surveyor interviewed CNA H (Certified Nursing Assistant). CNA H stated that she believes R3 had a bed bath the previous day. CNA H went into R3's room to observe him and then returned to Surveyor and stated his hair appeared unclean and was not washed the previous day. CNA H stated that, due to staffing, at times CNAs will do a quick bed bath as a shower or more thorough cleaning is not possible. Surveyor observed R3 approximately an hour later and his hair was washed and combed. The facility did not provide the necessary and regular hair care and washing to maintain R3's appearance and personal hygiene.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - 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** 39849 Based on observation, interview and record review, the facility did not ensure that a resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection, prevent new ulcers from developing, and a resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable in 1 of 3 residents reviewed for pressure injury concerns (R32) out of a total sample of 18. R32 was at risk for PI (Pressure Injury) development due to his diagnoses and health history. The facility failed to follow physician's orders and ensure interventions were in place to prevent the PI from developing or worsening. Evidenced by: According to the NPUAP's (National Pressure Ulcer Advisory Panel), Prevention and Treatment of Pressure Ulcers/Injuries Quick Reference Guide 2019: .Risk Factors and Risk Assessment 1.1 Consider individuals with limited mobility, limited activity and a high potential for friction and shear to be at risk of pressure injuries . 1.3 Consider the potential impact of an existing pressure injury of any Category/Stage on development of additional pressure injuries . 1.7 Consider the impact of diabetes mellitus on the risk of pressure injuries. 1.8 Consider the impact of perfusion and circulation deficits on the risk of pressure injuries . 1.10 Consider at the impact of impaired nutritional status on the risk of pressure injuries . 1.17 Consider the impact of time spent immobilized before surgery, the duration of surgery and the American Society of Anesthesiologists (ASA) Physical Status Classification on surgery-related pressure injury risk . 1.24 When conducting a pressure injury risk assessment: o Use a structured approach o Include a comprehensive skin assessment o Supplement use of a risk assessment tool with assessment of additional risk factors o Interpret the assessment outcomes using clinical judgment . According to the www.npuap.org <http://www.npuap.org> the NPUAP (National Pressure Ulcer Advisory Panel): Pressure Injury: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue. Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink, or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe Moisture Associated Skin Damage (MASD) including Incontinence Associated Dermatitis (IAD), Intertriginous Dermatitis (ITD), Medical Adhesive Related Skin Injury (MARSI), or traumatic wounds (skin tears, burns, abrasions). Stage 3 Pressure Injury: Full-thickness skin loss Full-thickness loss of skin, in which adipose is visible in the ulcer and granulation tissue and epibole are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. 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. Stable eschar (i.e., dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed. The Facility's Policy and Procedure titled, Skin Management Guideline, with an effective date of 11/28/17, indicates, in part: Purpose: To ensure residents that are admitted to the facility are evaluated to determine appropriate measures to be taken by the interdisciplinary care team to determine appropriate measures and individualized interventions to prevent, reduce and treat skin breakdown. It is the practice of this facility to properly identify and evaluate residents whose clinical conditions increase the risk for impaired skin integrity, and pressure ulcers; to implement preventative measures; and to provide appropriate treatment modalities for wounds according to industry standards of care .Procedure: I. Prevention of Pressure Ulcers * All residents admitted to the facility will be evaluated for actual and potential skin integrity issues . An individualized plan of care will be developed upon admission, reviewed, and updated quarterly and with a change in condition as needed. The plan of care will identify impairment and predicting factors. Interventions for prevention, removing and reducing predicting factors and treatment for skin may include: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	* Pressure redistribution surface for bed and seating surfaces: Specified through clinical evaluation and determination * Adaptive equipment and seating to support and encourage correct anatomical alignment . *Specified turning and repositioning . *Pressure, friction, shear reduction . B. Monitoring of Skin Integrity . *The Care Plan for Skin Integrity is to be evaluated and revised based on response, outcomes, and needs of resident . II. Treatment of Pressure Ulcers .If a resident is admitted with or there is a new development of a pressure ulcer or lower extremity ulcer the following procedure is to be implemented:1. Review the wound formulary for guidance 2. Consult with the Physician/NP and Resident Representative .6. Re-evaluate turning and repositioning interventions 7. Initiate Braden Scale and initiate investigation process if new onset .10. Initiate the Wound Initial Documentation Observation in PCC (Point Click Care) .The Weekly Wound Documentation Observation in PCC should only have ONE WOUND per observation . The Facility's Policy and Procedure titled, Skin Protection Guideline, with an effective date of 7/7/21, indicates, in part: Purpose: To provide evidenced based practice standards for the care and treatment of skin. To ensure residents that admit and reside at our facility are evaluated and provided individualized interventions to prevent, reduce and treat skin breakdown .Evaluation .The process includes evaluating: *Specific risk factors and changes in the resident's condition that may impact the development and/or healing of a PU/PI (Pressure Ulcer/Pressure Injury) *Implementing, monitoring, and modifying interventions to stabilize, reduce or remove underlying risk factors *If a PU/PI is present, provide treatment to heal and prevent the development of additional PU/PIs . The NPIAP (National Pressure Injury Advisory Panel) outlines the following (this list is not all inclusive and each resident must be reviewed for potential, individualized risk factors). Some factors are modifiable [NAME] [sic] others are not: *Limited mobility and activity *Friction *Shearing *Presence of current injuries: Risk for worsening and / [sic] or additional development (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	*Alterations in skin status over pressure points *Diabetes *Disease or condition that alters perfusion and create circulatory deficits . *Alterations in sensory perceptions *Immobilization before a surgery, the duration of surgery and related impacts on skin including: -Duration of crucial care stay -Mechanical ventilation -Use of vasopressors . An admission evaluation helps identify residents at risk of developing a PU/PI, and residents with existing PU/PIs. Because a resident at risk can develop PU/PI within hours of the onset of pressure, the at-risk resident needs to be identified and have interventions implemented promptly to attempt to prevent PU/PI . The admission evaluation helps define those initial care approaches. In addition, the admission evaluation may identify pre-existing signs suggesting that tissue damage has already occurred, and additional tissue loss may occur . Some situations, which may have contributed to this tissue damage prior to admission, include pressure resulting from immobility during hospitalization or surgical procedures, during prolonged ambulance transport, or while waiting to be assisted after a debilitating event, such as a fall or a cerebral vascular accident . Interventions Interventions for prevention, removing and reducing predicting factors and treatment for skin may include (This list is not all-inclusive): *Selection of an individualized support surfaces (A specialized device for pressure re-distribution designed for management of tissue loads, micro-climate and / or [sic] other therapeutic functions) for bed and seating to enhance pressure re-distribution *Specified through clinical evaluation and determination *Adaptive equipment and seating to support and encourage correct anatomical alignment . *Specified turning and repositioning . *Pressure, friction, shear reduction . (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R32 was admitted to the facility on [DATE], with diagnoses that include, in part: Displaced intertrochanteric fracture of right femur; Acute embolism and thrombosis of unspecified deep veins of right lower extremity; Rhabdomyolysis; Wedge compression fracture of unspecified thoracic vertebra; Unspecified Fall; Moderate Protein-Calorie Malnutrition; and Type II Diabetes Mellitus . R32's most recent MDS (Minimum Data Set) with a target date of 6/12/22, documents a BIMS (Brief Interview of Mental Status) score of 7, which indicates, a severe cognitive impairment. R32's Adult Hospital Medicine Admission History and Physical Note, with a date of service of 5/24/22, indicates, Pt reports having fallen four days ago in his kitchen after losing his balance. He landed on his right hip, crawled back into bed and has been there since. He had some food and drink near his bed, but that is all he has had since then. He did take his medications. The pt. endorses that he was urinating into bottles because he was unable to get up due to the pain . R32's Physician Transfer Order Report, indicates, in part: Active Problems: Acute deep vein thrombosis (DVT) of right lower extremity . It is important to note R32's report of decreased mobility while in bed for a 4-day period, decreased perfusion due to an acute DVT of the right lower extremity, decrease nutrient intake and the potential for friction and shear while crawling back to bed would increase R32's risk for developing PIs. R32's Physician Transfer Order Report, indicates, in part. Discharge Orders: Admit to: Skilled Nursing Facility . Dressing and Wound Orders: -Minimize pressure with frequent repositioning, scheduled turning every 2 hours with a 30-degree tilt -Therapeutic support surface (low air loss mattress). -Minimize friction and shear by keeping skin clean and moisturized (use lift sheet or TAPS (Turning and positioning system) system. -Incontinence management Current wound care recommendations include: Location: Left posterior thigh Frequency: Every 3 days and as needed if soiled, saturated, or loose. Cleanse wound gently with normal saline and gauze - Apply a thin layer of the Medihoney directly to the wound bed (approximately a nickel thickness) or onto a dressing. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Additional Dressing and Wound Instructions: -Minimize pressure with frequent repositioning, scheduled turning every 2 hours with a 30-degree tilt. -Therapeutic support surface (low air loss mattress) -Minimize friction and shear by keeping skin clean and moisturized (use of lift sheet or TAPS system) Expected Discharge & Plan (recommendations) Discharge cares as follows: Same as above. Manufacturer's recommendations were requested for R32's wheelchair cushion, mattress on admission, and current air mattress. On 8/17/22 at 2:49 PM Recommendations were provided for Direct Supply Panacea Immerse Mattress. The documentation does not note what stage PI the mattress is rated for. DOO R (Director of Operations) indicated she is still working on finding more information. The following information was provided to the Surveyor by the facility: -R32's mattress, on admission to the facility, is noted to be a Direct Supply Panacea Immerse Mattress with the following information noted on the manufacturer documents provided to Surveyor: *The mattress manufacturer has tested the technology used in the Panacea Immerse mattress to assess its comfort and pressure redistribution properties. A full study, entitled A prospective Study of a Unique Open-Cell Foam Mattress with a Modified Top Layer in hospitalized General Medical-Surgical Patients, is included for your convenience. The findings show that, when used properly as part of a comprehensive care program, the Panacea Immerse technology did not lead to skin breakdown in patients with intact skin at the time of admission, and improved existing skin integrity in over 75% of patients with existing decubitus ulcers . The facility also provided the Surveyor with information for Direct Supply Panacea ImmersaGel Mattress and highlighted the following information: These pressure redistribution support surfaces are appropriate for use as part of an overall care plan to prevent and treat decubitus ulcers. Resident-specific assessment could alter your usage of these mattresses. It is unclear based on the differing mattress information documents received from the facility, which mattress the resident was using on admission. The facility failed to implement physician admission orders for a low air loss mattress (LAL). Of note, there was no information regarding pressure injury prevention/treatment rating in the manufacturer's recommendations obtained from the facility. There is no evidence that the mattress R32 was using on admission was appropriate for his PI present on admission or to prevent future injury. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Of note, R32's Hospital Physician Transfer Report indicates Dressing and Wound orders for Left Posterior Thigh Wound, indicating a wound was present on discharge from the hospital. R32's Facility wound evaluation, dated 6/7/22, denotes an area of 5.53 cm x 4.07 cm to Left Thigh Lateral, with the wound bed documented as 100% eschar. Of note, a wound described as 100% eschar under current standards of practice would be categorized as an unstageable PI. -R32's current mattress, implemented on 6/22/22, is noted to be an Integra Healthcare Equipment True LAL (Low Air Loss Mattress) System. Product Description: Our True Low Air Loss System with Pulsation offers an extraordinary therapeutic mattress system for the prevention and treatment of pressure ulcers . Of note, R32 did not receive the LAL until 6/22/22, 10 days after the first documentation, on 6/12/22, of the left and right buttock pressure ulcers starting and 7 days after the coccyx wound can be seen on the June 15, 2022, Wound Evaluation picture. According to the NPUAP's (National Pressure Ulcer Advisory Panel), Prevention and Treatment of Pressure Ulcers/Injuries Quick Reference Guide 2019: .Support Surfaces 7.1 Select a support surface that meets the individual's need for pressure redistribution based on the following factors: o Level of immobility and inactivity o Need to influence microclimate control and shear reduction o Size and weight of the individual o Number, severity, and location of existing pressure injuries o Risk for developing new pressure injuries . 7.4 Use a high specification reactive single layer foam mattress or overlay in preference to a foam mattress without high specification qualities for individuals at risk of developing pressure injuries. 7.5 Consider using a reactive air mattress or overlay for individuals at risk for developing pressure injuries . 7.7 Assess the relative benefits of using an alternating pressure air mattress or overlay for individuals at risk of pressure injuries . 7.9 For individuals with a pressure injury, consider changing to a specialty support surface when the individual: o Cannot be positioned off the existing pressure injury o Has pressure injuries on two or more turning surfaces (e.g., the sacrum and trochanter) that limit repositioning options o Has a pressure injury that fails to heal or the pressure injury deteriorates despite appropriate comprehensive care o Is at high risk for additional pressure injuries o Has undergone flap or graft surgery o Is uncomfortable o 'Bottoms out' on the current support surface . R32's Skin and Wound Evaluation with an effective date of 6/7/22 indicates the following: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A. Describe 1. Type 5. Bruise .22. Location Right Antecubital Space 23. Acquired .2. Present on Admission 24. How long has the wound been present? 2. Exact Date .24a. Exact Date: 6/6/22 .I. Progress .3. Notes: Bruising noted to Right Antecubital Space. No open measurable areas noted. No concerns noted. Resolved on admission assessment . Of note: No other Skin or Wound areas are noted on this evaluation. R32's Braden scale evaluations (an evidenced-based tool that predicts the risk for developing a pressure injury) noted the following: *Effective date of 6/6/22, noted a score of 17 (at risk) *Effective date of 6/13/22, noted a score of 16 (at risk) *Effective date of 6/20/22, noted a score of 16 (at risk) R32's care plan documents the following, in part: Focus: The resident has an ADL (Activities of Daily Living) self-care performance deficit r/t (related to) fx. (fracture) of right femur, malnutrition, wedge compression fx. of thoracic spine, falls, malaise, alcohol abuse, heart disease and weakness. Date Initiated 6/6/22. Interventions/Tasks: Bed Mobility: Physical Assist x 2. Date Initiated 6/11/22. Transfers: Resident requires: 1 assist stand-pivot with 2ww (wheeled walker) to/from WC (wheelchair) to/from edge of bed . Focus: The resident has limited physical mobility r/t fx. of right femur, malnutrition, wedge compression fx. of thoracic spine, falls, malaise, alcohol abuse, heart disease and weakness. Date Initiated: 6/6/22. Interventions/Tasks: * Resident has a weight bearing restriction (NWB (non-weight bearing) to Right leg r/t hip fx.) Date Initiated: 6/6/22. *Uses Wheelchair (ensure foot pedals are in place). *Provide supportive care, assistance with mobility as needed. Document assistance as needed. Date Initiated: 6/6/22 . Focus: The resident has potential for impairment to skin integrity r/t limited mobility. Date Initiated: 6/6/22. Interventions/Tasks: *-Monitor skin when providing cares, notify nurse of any changes in skin appearance. Date Initiated: 6/6/22 . Focus: The resident has actual impairment to skin integrity to left and right buttocks and Right Thigh (Lateral) r/t abrasions and surgical incision. Date Initiated: 6/30/22. Interventions/Tasks: * Evaluate and treat per physicians' orders. Date Initiated: 6/6/22 . (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	* 6/22/22: The resident needs pressure relieving/reducing mattress i.e.: air mattress while in bed and continued use of cushion in wc. Date Initiated: 6/30/22 . * The resident needs assistance and reminding to reposition every 2-3 hours while in bed or in wheelchair. Date Initiated: 6/22/22 . Focus: The resident has bladder incontinence r/t limited mobility. Date Initiated: 6/6/22. Interventions/Tasks: * Clean peri-area with each incontinence episode. Date Initiated 6/6/22 . R32's CNA (Certified Nursing Assistant) care plan, documents the following in part: Skin: * 6/22/22: The resident needs pressure relieving/reducing mattress i.e.: air mattress while in bed, and continued use of cushion in the wc .Bed Mobility: * Bed Mobility: Physical Assist x 2 .Resident Care: *The resident needs assistance and reminding to reposition every 2-3 hours [NAME] in bed or in wheelchair . R32's Progress Notes document the following: 6/6/22 3:52PM Nursing Evaluation: (Admit, Readmit, Qtly, Annual Sig Change) . Resident admitted from: (Hospital Name) Skin Integrity: The resident has skin integrity concerns. 0 .Musculoskeletal: Resident has weakness. Location: Left hand and legs Resident has weight bearing restriction. Location: Weight bearing as tolerated right lower extremity. No ROM (Range of Motion) impairment to upper extremities. ROM impairment to RLE (Right Lower Extremity). The resident needs assistance with ADL's. Resident uses assistive device/s: Wheelchair . 6/12/22 5:55 PM (Created Date) Health Status Note (nurses note): Placed dressing to buttocks, pressure ulcers starting to bilateral buttocks, cleansed, and dressed with bordered gauze. Blanchable purple discoloration to buttocks/coccyx area. Educated resident to reposition q2hours (every), placed pillow under left side. Reported to oncoming nurse to reposition resident q2hours. Unstageable pressure ulcer to left gluteal fold noted, cleansed and Medahoney [sic] applied with bordered gauze. It is important to note the wound evaluation notes for the right and left buttock denote wound evaluation dates of 6/13/22 and note minutes old. 6/23/22 1:01 PM Health Status Note (nurses note). Note Text: Roho cushion ordered today for resident to use while in wheelchair. New wound care orders were obtained per discussion with provider .Re-education given to resident on importance of repositioning every two-three hours to promote healing and prevent further breakdown, resident was able to verbalize and understanding and repeat back education . Of note, Information obtained from the facility regarding R32's wheelchair cushion notes it is a Direct Supply Foam Cushion, not a Roho. Surveyor also observed R32's wheelchair with staff and noted a Foam Cushion with Direct Supply Label. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	6/27/22 3:25PM Health Status Note (nurses note) Note Text: During dressing change to left and right buttocks and coccyx, it was noted that wound continues to deteriorate. Slough noted to wound bed on coccyx with opening noted to center. Increased depth noted and tunneling at 12 o'clock of 3.8cm. Wound bed with foul smell. Moderate serosanguineous drainage. Provider, NP contacted. NP ordered to have resident sent out for further wound evaluation due to rapid deterioration . Of note, R32 declined to be interviewed or allow Surveyor to observe wound care. R32's Wound Evaluations documents include the following, in part: ---Left Thigh Lateral Evaluated on 6/7/22 #3 Abrasion Body Location: Left Thigh Lateral New - 1 day old Acquired: Present on Admission Dimensions: Length: 5.53cm Width 4.07cm Deepest Point 0cm Wound Bed: % Eschar 100% . Periwound: Edges - Epithelialization; Surrounding Tissue - Intact; Induration - None Present; Edema - No swelling or edema; Change in Temperature (Degrees) - 0; Periwound Temperature - Normal . Progress: New Notes: Wound noted to Left Thigh (Lateral) with complete eschar to wound bed. Small amount of old serosanguineous drainage noted to old dressing. No s/s of infection. Wound cleansed with wound cleanser, pat dried. Medihoney applied to eschar, covered with foam border, resident tolerated well. Provider updated . Of note, a wound described as 100% eschar, under current standards of practice, would be categorized as an unstageable PI. Evaluated on 6/8/22 #3 Abrasion Body Location: Left Thigh Lateral Stable - 2 days old Acquired: Present on Admission (continued on next page)

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	525330	A. Building B. Wing	08/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Middleton Village Nursing and Rehab	6201 Elmwood Ave Middleton, WI 53562

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 0686 Level of Harm - Actual harm Residents Affected - Few	Dimensions Length: 3.89cm Width 3.88cm Deepest Point 0cm Wound Bed: % Slough 10%; % Eschar 90% Periwound: Edges - Epithelialization; Surrounding Tissue - Intact; Induration - None Present; Edema - No swelling or edema; Change in Temperature (Degrees) - 0; Periwound Temperature - Normal . Progress: Stable Notes: Eschar noted to wound bed. Small amount of slough noted around the outer edges of wound bed. Small amount of serosanguineous drainage noted to old dressing. No s/s of infection. Wound care provided per order; resident tolerated it well. Evaluated on 6/15/22 #3 Abrasion Body Location: Left Thigh Lateral Stable - 9 days old Acquired: Present on Admission Dimensions: Length: 4.88cm Width 3.39cm Deepest Point 0.2cm Wound Bed: % Slough 10%; % Eschar 90% . Periwound: Edges - Epithelialization; Surrounding Tissue - Intact; Induration - None Present; Edema - No swelling or edema; Change in Temperature (Degrees) - 0; Periwound Temperature - Normal . Progress: Stable Notes: Wound bed with eschar and slough. Small amount of drainage noted. No s/s of infection. Wound care provided per order. Resident tolerated it well. Evaluated on 6/22/22 #3 Abrasion Body Location: Left Thigh Lateral Stable - 16 days old Acquired: Present on Admission Dimensions: Length: 4.2cm Width 3.84cm Deepest Point 0.4cm Wound Bed: %Granulation 10%; % Slough 60%; % Eschar 30% . (continued on next page)

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	525330	A. Building B. Wing	08/18/2022

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Periwound: Edges - Epithelialization; Surrounding Tissue - Erythema; Induration - None Present; Edema - No swelling or edema; Change in Temperature (Degrees) - 0; Periwound Temperature - Normal . Progress: Stable Notes: Wound bed with eschar and slough. Heavy serosanguineous drainage noted. Foul smell noted to wound bed. Wound care provided per order; resident tolerated well. Provider updated. It is important to note the following: R32's Physician Transfer Order Report, which includes a picture of R32's left posterior thigh, indicates under the picture: Large open wound, appears as this may have been a caused by traumatic injury. This is a typical for a pressure related injury. Measures 7.5cm x 7.5cm partial thickness wound. Further documentation notes: .Appraisal: -R32 with anasarca. -Wound to the posterior left upper posterior thigh appears as a possible skin tear with full flap loss. There is no surrounding tissue erythema and is a typical for pressure related injury . -Low air loss mattress in place d/t R32's low mobility status . Based on Surveyor review of wound care documentation and pictures (Best seen on June 22, 2022, documentation) provided by the facility, along with review of The Physician Transfer Report documentation, the body location appears to be the same posterior aspect of the left thigh versus the lateral thigh description given in facility wound evaluations. R32's Physician order, dated 6/6/22, includes in part: Left Posterior thigh. Cleanse wound with normal saline and gauze. Apply thin layer of Medihoney directly to wound bed. Use Mepilex sacral dressing . ---Left Buttock Evaluated on 6/13/22 #5 Abrasion Body Location: Left Buttock New - Minutes old Acquired: In-House Acquired Dimensions: Length: 2.8cm Width 2.8cm Wound Bed: %Granulation 100% . (continued on next page)

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	525330	A. Building B. Wing	08/18/2022

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Periwound: Edges - Attached; Surrounding Tissue - Erythema Fragile; Induration - None Present; Edema - No swelling or edema; Change in Temperature (Degrees) - 0; Periwound Temperature - Normal . Progress: New Notes: Abrasion noted to left buttock. Open area with granulation tissue. Peri-wound very fragile, erythema noted, area non-blanchable. Wound cleansed with wound cleanser, pat dried. Covered with foam border. Provider updated. Evaluated on 6/15/22 #5 Abrasion Body Location: Left Buttock Stable - 2 days old Acquired: In-House Acquired Dimensions: Length: 3.74cm Width 3.91cm Wound Bed: %Granulation 100% .Other - Pink or red . Periwound: Edges - Attached; Surrounding Tissue - Erythema; Induration - None Present; Edema - No swelling or edema; Change in Temperature (Degrees) - 0; Periwound Temperature - Normal . Progress: Stable Notes: Wound bed with granulation tissue. Peri-wound with erythema. Moderate amount of drainage noted. No s/s of infection. Wound care provided per order; resident tolerated it well. Education: Educated resident on the importance of repositioning every 2-3 hours to promote healing, resident verbalized an understanding . Evaluated on 6/22/22 #5 Abrasion Body Location: Left Buttock Stable - 9 days old Acquired: In-House Acquired Dimensions: Length: 3.5cm Width 3.23cm Wound Bed: %Epithelial 10% .%Granulation 10% .%Slough 80% .Other - Pink or red . (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Periwound: Edges - Epithelialization; Surrounding Tissue - Erythema; Induration - None Present; Edema - No swelling or edema; Change in Temperature (Degrees) - 0; Periwound Temperature - Normal . Progress: Stable Notes: Wound bed with slough, granulation tissue and epithelial tissue. Moderate amount of serosanguineous drainage noted. No s/s of infection. Wound care provided per order; resident tolerated it well. Provider contacted with update on wound . Of note, a wound described as 80% slough, 10% Epithelial, and 10% Granulation, under current standards of practice, would be categorized, at a minimum, as a stage III PI. This would be considered a deterioration in this wound. It is important to note that on Surveyor review of the different wound evaluation pictures provided of Left Buttock, there are areas of dark purple discoloration noted to right and left buttock. ---Right Buttock Evaluated on 6/13/22 #6 Abrasion Body Location: Right Buttock New - Minutes old Acquired: In-House Acquired Dimensions: Length: 1.49cm Width 1.79cm Deepest Point 0cm Wound Bed: %Granulation 100% .Other - Pink or red. Periwound: Edges - Attached; Surrounding Tissue - Erythema Fragile; Induration - None Present; Edema - No swelling or edema; Change in Temperature (Degrees) - 0; Periwound Temperature - Normal. Progress: New Notes: Abrasion noted to right buttock. Open area with granulation tissue. Peri-wound with erythema, blistering and fragile skin. Small amount of serosanguineous drainage noted. No s/s of infection. Wound cleansed with wound cleanser, pat dry. Covered with foam border dressing. Provider updated. Of note, a wound described as 100% Granulation, under current standards of practice, would be categorized as a stage III PI. It is important to note that on Surveyor review of the picture provided for the 6/13/22 wound evaluation documentation, it appears there is an area dark purple/red discoloration noted on right buttock, sacral/coccyx area, and left buttock. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525330	A. Building B. Wing	08/18/2022

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Evaluated on 6/15/22 #6 Abrasion Body Location: Right Buttock Deteriorating - 2 days old Acquired: In-House Acquired Dimensions: Length: 6.5cm Width 3.44cm Deepest Point 0.1cm Wound Bed: %Epithelial 40% .%Granulation 50% .%Slough 10% .Other - Pink or red . Periwound: Edges - Attached; Surrounding Tissue - Blister Fragile; Induration - None Present; Edema - No swelling or edema; Change in Temperature (Degrees) - 0; Periwound Temperature - Normal . Progress: Deteriorating Notes: No dressing in place upon assessment. New open areas noted to coccyx area, granulation tissue noted. Epithelial and granulation tissue noted to other areas. Periwound with erythema, blister, and fragile skin. Moderate amount of serosanguineous drainage noted. No s/s of infection. Wound care provided per order; resident tolerated it well. Provider updated. It is important to note that on Surveyor review of the picture provided for the 6/15/22 wound evaluation documentation, it appears there is an area of slough on the coccyx area. There is also dark purple/red/black discoloration noted on right buttock and coccyx area. It is not clear if the measurements are for the entire area or just the open right buttock wound. <b[TRUNCATED]