STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525482	A. Building B. Wing	03/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Burlington Health and Rehabilitation Center	677 E State St Burlington, WI 53105

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 - 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** 38253 Based on observation, record review, and interview, the facility did not comprehensively assess a resident on admission to ensure interventions were implemented to prevent the development of pressure injuries for 1 (R2) of 3 residents reviewed for pressure injuries. R2 was admitted to the facility on [DATE] and a Licensed Practical Nurse (LPN) completed the admission assessment form where redness was noted to R2's right and left buttocks and sacral area. A comprehensive skin assessment was not completed by a Registered Nurse (RN) at that time and there were no interventions. An LPN noted R2 had a red area to the right and left buttocks and sacral area on 2/14/2022 and an RN was not notified to comprehensively assess the area. On 2/15/2022, R2 was found to have an Unstageable pressure injury to the right buttock, a Deep Tissue Injury (DTI) to the left buttock, and a DTI to the left heel. According to N6 Wisconsin Nurse Practice Act, an LPN can collect data, but an RN is responsible for assessing, planning, intervening and evaluating. The Facility failure to ensure an RN comprehensively assessed a newly admitted resident for skin integrity, despite a reddened area noted on the buttock on 2/9/22 and again on 2/14/22, and the resulting failure to put more stringent measures in place to prevent the reddened areas from worsening led to an unstageable pressure injury, which became infected and required debridement and antibiotics. When the facility did implement two-hour repositioning on 2/15/22, the facility did not change the certified nursing assistant (CNA) care card. The failure to comprehensively assess and revise the resident's care plan to prevent the worsening of R2's skin condition and pressure injury created a finding of immediate jeopardy that began on 2/9/2022. Surveyor notified Nursing Home Administrator (NHA)-A of the immediate jeopardy on 3/22/2022 at 8:45 AM. The immediate jeopardy was removed on 3/24/22 and continues at a scope and severity level of E (potential for harm/pattern) as the facility continues to implement and monitor the effectiveness of their removal plan for the 44 residents identified to be at risk for the development of pressure injuries. Findings include: (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility policy and procedure entitled Admission Assessment and Follow Up: Role of the Nurse dated 9/2012 states: The purpose of this procedure is to gather information about the resident's physical, emotional, cognitive, and psychosocial condition upon admission for the purposes of managing the resident, initiating the care plan, and completing required assessment instruments, including the MDS. 8. Conduct a physical assessment, including the following systems: . j. Skin. 9. Conduct supplemental assessments (following facility forms and protocol) including: . e. Skin assessment: . Reporting: 1. Notify the supervisor and the Attending Physician of immediate needs that the resident may have. 3. Report other information in accordance with facility policy and professional standards of practice. The facility policy and procedure entitled Prevention of Pressure Ulcers/Injuries dated 7/2012 states: The purpose of this procedure is to provide information regarding identification of pressure ulcer/injury risk factors and interventions for specific risk factors. Preparation: Review the resident's care plan and identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable. Risk Assessment: 1. Assess the resident on admission (within eight hours) for existing pressure ulcer/injury risk factors. Repeat the risk assessment weekly and upon any changes in condition. 2. Conduct a comprehensive skin assessment upon admission, including: a. Skin integrity - any evidence of existing or developing pressure ulcers or injuries; b. Tissue tolerance - the ability of the skin (and supporting structures) to endure the effects of pressure; and c. Areas of impaired circulation due to pressure from positioning or medical devices. 3. Use a screening tool to determine if resident is at risk for under-nutrition or malnutrition. 4. Inspect the skin on a daily basis when performing or assisting with personal care or ADLs. a. Identify any signs of developing pressure injuries (i.e., nonblanchable erythema). b. Inspect pressure points (sacrum, heels, buttocks, coccyx, elbows, ischium, trochanter, etc.); c. Wash the skin after any episodes of incontinence, using pH balanced skin cleanser; d. Moisturize dry skin daily; and e. Reposition resident as indicated on the care plan. Mobility/Repositioning: (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. Choose a frequency for repositioning based on the resident's mobility, the support surface in use, skin condition and tolerance, and the resident's stated preferences. 2. At least every hour, reposition residents who are chair-bound or bed-bound with the head of the bed elevated 30 degrees or more. 3. At least every two hours, reposition residents who are reclining and dependent on staff for repositioning. 4. Reposition more frequently as needed, based on the condition of the skin and the resident's comfort. Support Surfaces and Pressure Redistribution: Select appropriate support surfaces based on the resident's mobility, continence, skin moisture and perfusion, body size, weight, and overall risk factors. Monitoring: 1. Evaluate, report and document potential changes in the skin. 2. Review the interventions and strategies for effectiveness on an ongoing basis. The facility policy and procedure entitled Skin Management Guidelines Practice Guidelines dated 10/2021 states: . Newly admitted Residents: Upon admission, all residents are assessed for skin integrity within 8 hours of admission by completing a head to toe physical assessment and documenting on the admission assessment and completing the Braden Scale - For Predicting Pressure Sore Risk . Following admission; the Braden Scale - For Predicting Pressure Sore Risk in (the computer charting system) will be completed weekly for 3 additional weeks (for a total of 4 weeks including admission), quarterly, annually, and with a change of condition, for their risk for development of pressure injury. A resident risk may increase due to an acute illness or condition changes (URI, Pneumonia, or exacerbation of underlying CHF, etc) and may require additional evaluation. Therefore it is recommended a repeat Braden assessment be completed if a resident has a significant change of condition. Nurse aides will complete body audits at least weekly, but preferably with every bathing opportunity. The body audits post shower will be turned into the licensed nurse to review for changes in skin condition. Appropriate preventive measures will be implemented on all residents identified at risk (score of 18 or less on the Braden Scale - For Predicting Pressure Sore Risk), and the interventions documented on the Care Plan . A Care Plan is developed upon admission, identifying the contributing risks for breakdown, including history of skin impairment or the actual impairment (there should be separate care plans for Risk of and actual), and the interventions implemented to promote healing and prevent further breakdown. The Care Plan should address, but is not limited to: Hydration, Nutrition, Preventive devices, Physical Activity, Pain, Positioning requirements, Proper Body Alignment . (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 2/3/2022, R2 was sitting in a wheelchair at home when R2 fell asleep and fell forward landing face first on the ground sustaining a bruise to the forehead. R2 was transported to the hospital and admitted with acute kidney injury and cellulitis of the right leg with an ulcer requiring intravenous (IV) antibiotics. The hospital records on 2/9/2022 included documentation of wounds to the left great toe due to trauma, the left second toe due to trauma, and a venous ulcer to the right lower leg that measured 1.5 cm x 1.4 cm x 0.1 cm. There was no documentation of a wound or area of concern to the right or left buttock or sacrum. Patient Discharge Instructions from the hospital on 2/9/2022 stated activity as tolerated, resume prior diet, and see provided instructions for wound care. No hospital instructions for wound care were found in R2's facility record. R2 was admitted to the facility on [DATE] with diagnoses of morbid obesity, hyperlipidemia, atrial fibrillation, osteoarthritis, venous hypertension with ulcer of the right lower leg, coronary artery disease, and hypertension. Admission orders on 2/9/2022 for R2 included aspirin 81 mg daily and Coumadin 4 mg Wednesday, Thursday, and Saturday and 6 mg Sunday, Monday, Tuesday, and Friday for atrial fibrillation, and cephalexin 500 mg three times daily for four days for cellulitis to the right lower leg. On 2/9/2022, LPN-C did the admission assessment of R2. The Skin section of the assessment documented an abrasion to the top of the scalp on the left side, bruising to the back of the right hand, redness to the front of the right lower leg, a vascular ulcer to the front of the right lower leg measuring 1.5 cm x 0.7 cm x 0 cm, and the left toe was missing the great toenail. No other areas were documented on this form. LPN-C had a hand-written worksheet dated 2/9/2022 with vital signs and a body diagram that had the same areas circled as documented above as well as a large circle around the sacral/buttocks area that said redness. No measurements or other descriptors of the area were documented. No documentation was found by Surveyor that an RN assessed R2's skin. On 2/9/2022, a Braden scale was completed that had a score of 13 indicating moderate risk of skin breakdown. A baseline care plan was done on 2/9/2022 by Director of Nursing (DON)-B that indicated R2 had -a special mattress, -heel protectors/elevate heels, -reposition every 2-3 hours, -wound to the buttocks/sacrum that was present prior to admission. -was incontinent of bowel -had a foley catheter (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-aids used for transfers (example: Hoyer) but did not specify what type of lift was to be used No bathing or toileting plan was completed on the baseline care plan. In an interview on 3/21/2022 at 10:00 AM, Director of Nursing (DON)-B stated the wound to the buttocks and sacrum written on the baseline care plan was in reference to the reddened area that LPN-C noted on admission. Surveyor asked DON-B if DON-B had assessed R2's skin on 2/9/2022. DON-B stated DON-B never looked at R2's skin but was told by LPN-C that the sacral area had blanchable redness and so DON-B put it on the care plan for staff to monitor the area. Surveyor asked DON-B and Corporate RN-F what kind of specialty mattress did R2 have in place on 2/9/2022. Corporate RN-F stated the mattress was a pressure-reducing mattress that is on all resident beds. Surveyor clarified R2 did not have an alternating pressure mattress. Corporate RN-F confirmed R2 did not have an alternating pressure mattress on 2/9/2022. On 2/10/2022 at 3:23 AM in the progress notes, nursing charted R2 was on oral antibiotics for cellulitis and the right lower leg dressing was intact. Surveyor reviewed R2's admission orders and no orders were found for a dressing to the right lower leg. On 2/10/2022 on the Physical Therapy (PT) evaluation, PT charted R2 demonstrated excellent rehab potential with the ability to participate in tasks of increased complexity, ability to safely adapt to change, ability to self-correct, able to make needs known, active participation in skilled treatment, high prior level of function, motivated to participate, motivated to return to prior level of living, strong family support, high cognitive functioning, ability to follow 2-step directions, ability to imitate targets, able to scan environment, active participation with plan of treatment and attentive to tasks. On 2/10/2022 on the PT Treatment Encounter note, PT charted R2 exhibited limited motion of lower extremities due to increased pain with movement and reported feeling apprehensive to sit at the edge of the bed. Per R2, the sheet does not slide like the sheets at home. PT recommended R2 to be a Hoyer lift for transfers and a maximum assist for bed mobility. On 2/10/2022 on the Occupational Therapy (OT) evaluation, OT charted that due to documented physical impairments and associated functional deficits, without skilled therapeutic intervention, R2 is at risk for decreased ability to return to prior level of assistance, decrease in level of mobility, decreased participation with functional tasks, and falls. On 2/14/2022 on the OT Treatment Encounter note, OT charted R2 was lying on the bed and needed maximum assist of two for rolling in either direction with R2 stating R2 was stiff all over. R2 was very challenged with rolling, needing maximum assist of one to bring legs to the edge of the bed and moderate assist of two to bring R2 to an upright position on the edge of the bed. R2 needed maximum assist of two to lie back down with cuing to lean into the right elbow and maximum assist to bring legs up onto the bed. R2 sat on the edge of the bed for approximately 14 minutes. R2 attempted with the use of a sit-to-stand lift to get buttock partially off the bed before needing to sit down with assistance of two. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 3/21/2022 at 10:45 AM, Certified Nursing Assistant (CNA)-E stated bath sheets are filled out by the CNA when a bath or shower is done. CNA-E stated the front of the sheet shows what is provided to the resident with the shower or bath and then the comment section on the bottom of the front is where any skin concerns are written or if the resident wanted a bed bath instead of a shower. CNA-E stated the form is then signed by the CNA and given to the nurse on the floor who signs the form and does the skin check on the back of the sheet. The back of the sheet has a diagram of the front and back of a body and a place for the signature of who completed the form and a place for the nurse's signature. CNA-E stated the form is then put in a plastic filing unit mounted on the wall of the nurses' station where the DON or unit manager collects them. On 2/14/2022 at 7:00 PM on the shower sheet/skin check sheet, a circle was hand-written around the buttocks/sacrum area and RED was written in capital letters on the body diagram on the back of the form. The front of the form had a signature by a CNA and an LPN. No signatures were on the back of the form to indicate who circled the area of concern. No measurements were documented of the area of concern. No documentation was found by Surveyor that an RN assessed R2's skin. The CNA and LPN were not available for interview. On 2/15/2022 on the PT Treatment Encounter note, PT charted R2's incontinence brief was inspected, and dry blood was noted around the penile/catheter site. PT addressed care to the area and noted stool in the brief. R2 was dependent for rolling and during the care, a large sacral wound with eschar was found. The therapist informed the nurse who then retrieved the Regional Director of Nursing to observe the wound. R2 was dependent on assist of two to maintain lying on the side. Once nursing addressed and noted the wound, R2 was returned to lying on the back and was dependent on two to three to assist scooting up in bed. R2 had heels floated with a pillow. On 2/15/2022 on the OT Treatment Encounter note, Certified Occupational Therapy Assistant (COTA)-H charted R2 was lying in bed upon entering the room and stated R2 was on the bed pan. After COTA-H returned to the room, R2 stated R2 was not sure if R2 was on a bed pan or not. COTA-H confirmed R2 was not on a bed pan and had a bowel movement in the incontinence brief. COTA-H charted PT was with COTA-H at the encounter and together, due to maximum assistance of two to roll R2 to roll in either direction, attempted to clean R2 up. R2 complained of moderate back pain when bed was partially lowered and when rolled. R2 was rolled onto the right side and COTA-H charted COTA-H noticed a pink bandage on the left buttock cheek as well as blackened skin on the right buttock cheek that was difficult to see as R2 was lying on the right side. R2 needed slow careful rolling to return to the back and resting before rolling to the left side for cleaning and putting a clean incontinence brief on. COTA-H charted after rolling R2 to the left, the right buttock cheek was noted to have a large, blackened area and nursing was notified. COTA-H and PT assisted in holding R2 on the side while Corporate RN-F measured the wounds and R2 was then cleaned. COTA-H documented R2 was unaware of a sore on the bottom and could not remember if one had been present before. R2 was returned to the back position, scooted up in bed, and sat up for breakfast with the recommendation to be placed on the side every two hours. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 3/21/2022 at 11:22 AM, COTA-H stated COTA-H and a PT assistant had gone into R2's room on 2/15/2022 to do therapy with R2, but R2 thought R2 was on the bedpan. COTA-H stated R2 was not on the bedpan but had been incontinent of bowel in a brief so COTA-H and the PT assistant decided to assist nursing staff and clean R2 up. COTA-H stated R2 had a pink patch or bandage on the left cheek and when they rolled R2 over the other way, they could see the right cheek looked black. COTA-H stated the area was quite large and black and could not understand how no one up until that time had not noticed the area. Surveyor did not find any documentation in R2's record of a dressing being ordered or applied to R2's left buttock prior to 2/15/2022. In an interview on 3/21/2022 at 10:55 AM, CNA/Med Tech (MT)-G stated on 2/15/2022 CNA/MT-G was passing medications on the unit and therapy reported to CNA/MT-G that R2 had something on R2's bottom. CNA/MT-G stated CNA/MT-G went to look at R2 and that was the first time CNA/MT-G had seen R2's skin. CNA/MT-G stated CNA/MT-G immediately got Corporate RN-F to look at the wounds. On 2/15/2022 on the Initial Wound Assessment form, Corporate RN-F documented R2 had an Unstageable Pressure Injury to the right buttock that measured 13.3 cm x 6.8 cm x 3.2 cm with 70% granulation, 7% slough, 7% eschar, 16% epithelialization with a small amount of serosanguineous drainage. On 2/15/2022 on the Initial Wound Assessment form, Corporate RN-F documented R2 had a Suspected Deep Tissue Injury to the left buttock that measured 7.6 cm x 4.7 cm x 0.1 cm with 97% granulation and 3% eschar with moderate amount of serous drainage. On 2/15/2022 on the Initial Wound Assessment form, Corporate RN-F documented R2 had a Suspected Deep Tissue Injury to the left heel that measured 1.7 cm x 1.8 cm with no description of the color of the area. The left heel Deep Tissue Injury was comprehensively assessed weekly. Wound Physician-I was in the facility on 2/15/2022 and assessed R2 at that time with Corporate RN-F. A treatment was ordered for the three pressure injury wounds, ProStat 30 ml twice daily was ordered, and R2 was placed on bedrest. In an interview on 3/21/2022 at 12:49 PM, Wound Physician-I stated on 2/15/2022 when the pressure injuries were initially looked at, the right buttock was an unstageable pressure injury and the left buttock was a deep tissue injury. Surveyor asked Wound Physician-I if there was any granulation tissue to the left buttock. Wound Physician-I stated the left buttock was not open and had the characteristics of a deep tissue injury with partial thickness damage but was not really open that turned into black eschar. Wound Physician-I stated the right buttock wound was debrided on 2/15/2022. Surveyor asked Wound Physician-I if any interventions were ordered to prevent further breakdown. Wound Physician-I stated staff were verbally told to turn R2 side to side as much as possible but there were no written orders. R2's Potential/Actual Impaired Skin Integrity Care Plan was created on 2/15/2022 with the following interventions: -Wound Physician consult -Treatment as ordered (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Bed rest at this time -Protein meal supplement -Labs -Float heels in bed/heel boots in bed -Turn and reposition every two hours -Apply cushion to wheelchair -Barrier cream after each incontinent episode and as needed -Complete Braden scale on admission, weekly times 4, quarterly, with significant change, and as needed -Free float heels in bed -Weekly skin assessment -Monitor skin with all cares; report any changes to nurse -Update physician as needed -Refer to Registered Dietician as needed -Assist to reposition every 2-3 hours and as needed was put in the care plan and removed from the care plan on 2/15/2022 -Pressure redistribution mattress was put in the care plan and removed from the care plan on 2/15/2022 -Alternating pressure mattress On 2/19/2022 at 3:21 PM in the progress notes, nursing charted the Nurse Practitioner was aware of the lab results for R2 and Coumadin was placed on hold until 2/20/2022 due to elevated PT/INR (Prothrombin Time/International Normalized Ratio) indicating an increased potential for bleeding. R2's Potential/Actual Impaired Skin Integrity Care Plan was revised on 2/20/2022 with the following interventions: -Float heels in bed -Heel boots in bed -Turn and reposition every 2 hours (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 2/22/2022 on the Weekly Wound Assessment form, Corporate RN-F documented the left and right buttock pressure injuries merged to become one Unstageable pressure injury to the sacrum/bilateral buttocks measuring 13.9 cm x 15.8 cm x 5.5 cm with 25% eschar, 25% necrotic, and 50% adipose tissue with a small amount of serosanguineous drainage. In the comment section of the form, Corporate RN-F documented the area was debrided by Wound Physician-I and there was a moderate amount of bleeding. Dakins wet to dry ABD pad and calcium alginate were placed on the wound. R2 was instructed to lay on the back for two hours and then have the wound rechecked for bleeding. If bleeding was noted at that time, Wound Physician-I was to be notified. On 2/22/2022 at 11:12 AM in the progress notes, Corporate RN-F charted R2 was seen by the wound team and Wound Physician-I. The left and right buttock wounds were debrided and are now listed as one wound to the sacrum/bilateral buttocks as unstageable. There was a moderate amount of bleeding during the procedure with one area covered with calcium alginate to help stop the bleeding. The wound was packed with Dakins wet kerlix and covered with two ABD pads. R2 was positioned on the back to help aid in stopping any active bleeding. R2 was to stay on the back for two hours and then have staff check for bleeding. If there is still bleeding, Wound Physician-I was to be notified. On 2/22/2022 at 1:18 PM in the progress notes, Corporate RN-F charted debridement had been done at 1:15 PM and staff are aware to check on the wound for bleeding in two hours. On 2/22/2022 at 3:29 PM in the progress notes, DON-B charted the dressing was pulled down and had a moderate amount of dark red blood drying on the dressing. Calcium alginate was still in place and no active bleeding was noted at that time. R2 did not have any complaints of pain and was positioned on the back to continue to have pressure applied to the area. On 2/22/2022 at 5:45 PM in the progress notes, nursing charted the dressing was checked and R2 was still having active bleeding from the wound. Wound Physician-I was notified, and orders were received to send R2 to the hospital for evaluation and treatment of the bleeding. On 2/22/2022 at 9:04 PM in the progress notes, nursing charted 911 was called and the paramedics arrived at approximately 5:30 PM. On 2/22/2022 on the emergency room report, R2 received the following care and treatment: R2 presents to the emergency department for evaluation of bleeding sacral wound. The patient had 3 distinct areas of bleeding on his sacral wound. Two of them were able to be stopped with silver nitrate sticks. However 1 of them was unable to be controlled by silver nitrate as it had continuous oozing. I tried TXA (Tranexamic Acid) soaked gauze as well. However this did not stop the bleeding. I discussed the case with (another physician). He recommended Vicryl sutures to the area of oozing. For [sic] (4) Vicryl sutures were placed in that area in a figure-of-eight pattern which did allow for hemostasis of the bleeding areas. Patient was otherwise well appearing and plan for discharge back to his nursing facility given that he has hemostasis at this time. Patient to follow-up with his wound care physician there for further management. Patient is to follow up with (physician named) . Schedule an appointment as soon as possible for a visit in 1 week. On 2/22/2022 at 11:06 PM in the progress notes, nursing charted R2 returned with three sutures in place and bleeding controlled. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R2's Potential/Actual Impaired Skin Integrity Care Plan was revised on 2/22/2022 with the following intervention: turn and reposition side to side every 2 hours. On 2/23/2022 at 11:38 AM in the progress notes, nursing charted the Nurse Practitioner approved the Registered Dietician's recommendation for multivitamins with minerals and Med Pass 2.0 supplement 90 ml twice daily. On 2/23/2022 at 2:56 PM in the PT Treatment Encounter Note, PT charted due to recent change of status-sacral pressure sore- pt (patient) has been placed on bed rest**-- [sic] this pressure sore was present before entry to facility and eval, but not documented or known of-until therapy discovered during a session. approached pt for session, no bed mobility can be performed, pt kept EC during interation [sic] (R2 kept ending conversation during interaction), eventually pt stopped responding to writers inquiries. Writer then left room. On return, pt demo'd (demonstrated) minimal response to writer, will assess pt next session. On 2/23/2022 in the OT Treatment Encounter Note, OT charted Writer returned later, with pt (patient) up in WC (wheelchair), awaiting new mattress to be aired up, expressing discomfort after ~10 min (approximately ten minutes). Writer then assisted CNA in returning pt to bed and adjusting air and positioning, following hoyer transfer. Pt stated being more comfortable following bed change. In an interview on 3/21/2022 at 1:15 PM, DON-B stated the facility had to get a rental alternating pressure mattress because there was a problem with the motor one night with the mattress they were using, and the mattress was replaced the next day. DON-B stated the mattress had to be kept on static instead of alternating pressure for it to work. Surveyor reviewed the delivery invoice of the low air loss mattress and pump. The invoice was dated 2/24/2022 with delivery time of 12:00 Noon. Per the OT note on 2/23/2022, a mattress was obtained on 2/23/2022 to replace a malfunctioning mattress and with the delivery date of 2/24/2022 for another mattress, R2 had a malfunctioning mattress for at least 24 hours. On 2/26/2022 at 2:15 PM in the progress notes, nursing charted wound care to the coccyx was completed with a large amount of serous drainage on the old dressing. R2 was instructed on the importance of changing position every two hours and keeping off the wound as much as possible. R2 verbalized understanding. On 2/27/2022 at 3:39 AM in the progress notes, nursing charted R2 does not like to reposition/turn side to side with rounds. The air mattress was functioning. On 3/1/2022 on the Weekly Wound Assessment form, Corporate RN-F documented the Unstageable pressure injury to the sacrum/bilateral buttocks measured 15.7 cm x 18.2 cm x 4.7 cm with 25% granulation and 75% eschar with a small amount of serosanguineous drainage. In the comments section of the form, Corporate RN-F documented R2 was seen by the wound team and Wound Physician-I. The wound was debrided with a moderate amount of eschar and necrotic tissue. R2 tolerated the debridement without complaints and with minimal bleeding. A culture was taken of the wound. Wound Physician-I informed Corporate RN-F there were no signs or symptoms of infection and would get a complete blood count (CBC) ordered for 3/2/2022. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525482	A. Building B. Wing	03/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Burlington Health and Rehabilitation Center	677 E State St Burlington, WI 53105

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/1/2022 at 8:01 AM in the PT Discharge Summary, PT charted R2 is unable to progress towards goals and level of indep (independence) d/t (due to) significant sacral wound status placing pt (patient) at bed rest per nursing. Plan is for pt to stay LTC (Long Term Care) at this time. May benefit with reassessment of functional status upon clearance of bed rest/wound status. On 3/2/2022 at 11:03 AM in the progress notes, nursing charted a new order was received from Wound Physician-I to start Rocephin 1 Gm intramuscularly (IM) daily for two weeks and doxycycline 100 mg twice daily for two weeks for possible wound infection. The CBC on 3/2/2022 had an elevated white blood count of 13.8 indicating an infectious process and the culture of the wound had grown out pseudomonas aeruginosa and bacteroides thetaiotaomicron. On 3/2/2022 at 12:47 PM in the progress notes, nursing charted the CBC and culture and sensitivity from the wound culture were reviewed and the doxycycline was discontinued, and the IM Rocephin was changed to IV Rocephin. A new order for Vancomycin 1 Gm IV daily for two weeks was given. A PICC line was to be inserted. Surveyor reviewed R2's Medication Administration Record (MAR). R2 received the following antibiotics: -3/2/2022: Ceftazidime (Fortaz) 1 GM IM daily -3/4/2022-3/5/2022: Ceftriaxone (Rocephin) 1 GM IV daily and Vancomycin 1 GM IV daily -3/6/2022-current: Ciprofloxacin 500 mg IV twice daily (only received one dose on 3/6/2022 and 3/7/2022) and Metronidazole 500 mg IV twice daily (only received one dose on 3/6/2022, 3/7/2022, and 3/8/2022) On 3/8/2022 on the Weekly Wound Assessment form, Corporate RN-F documented R2's sacrum/bilateral buttocks Unstageable pressure injury measured 15.3 cm x 20.1 cm x 4.4 cm with 25% granulation and 75% eschar with a small amount of serosanguineous drainage. In the comments section of the form, Corporate RN-F charted the wound was debrided by Wound Physician-I with minimal bleeding and R2 continued IV antibiotics. On 3/15/2022 on the Weekly Wound Assessment form, Corporate RN-F documented R2's sacrum/bilateral buttocks Unstageable pressure injury measured 14.0 cm x 17.3 cm x 4.7 cm with 50% granulation and 50% eschar with undermining from 11 o'clock to 4 o'clock measuring 4.7 cm with a scant amount of serous drainage. In the comments section of the form, Corporate RN-F charted the wound was debrided by Wound Physician-I with minimal bleeding. Undermining was now present and R2 continued IV antibiotics. R2's Potential/Actual Impaired Skin Integrity Care Plan was revised on 3/15/2022 with the following interventions: -3/2/22 Intramuscular (IM) antibiotic, labs, and wound culture -3/5/22 Peripherally inserted central catheter (PICC) care and flushes, intravenous (IV) antibiotic as ordered, monitor for adverse reaction to antibiotic (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R2's Actual Infection to Sacral/Buttocks Wound Care Plan was created on 3/15/2022 with the following interventions: -Administer antibiotics per physician order -Cares and flushes of IV/PICC line per policy -Encourage fluids -Monitor IV site every shift; report any redness, swelling, or signs/symptoms of infiltrate -Monitor labs as ordered -Notify physician or nurse of signs/symptoms of adverse response to antibiotic/treatment R2's Potential/Actual Impaired Skin Integrity Care Plan was revised on 3/21/2022 with the following intervention: may remove soft boots for 15 minutes per R2's request. R2's CNA Care Card obtained on 3/21/2022 informing the CNA staff caring for R2 of R2's needs had the following information: -Bath Day: Monday PM shift -Transfer Status: assist of two with a mechanical lift (the type of mechanical lift is not designated) -ADL (activities of daily living): assist of 1 -Safety Devices and Appliance [TRUNCATED]

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 16584 Based on record review and staff interview, the Facility did not ensure there was a QAPI (Quality Assurance Performance Improvement) meeting held at least quarterly with the required committee members in order to identify issues through the committee. This deficient practice had the potential to effect all 116 residents currently in the facility. Findings include: On 3/24/22 1:30 p.m. Surveyor reviewed the Facility's QAPI plan with attendance sign in sheets provided by Administrator-A. The Quality Assurance Performance and Improvement meeting minutes dated 3/10/21 does not include the Administrator's signature or the Medical Director's signature, which would indicate the Administrator and Medical Director did not attend the meeting. The Quality Assurance Performance and Improvement meeting minutes dated 6/9/21 does not include the Administrator's signature, which would indicate the Administrator did not attend the meeting. The Quality Assurance Performance and Improvement meeting minutes dated 9/8/21 does not include the Director of Nurse's signature, which would indicate the Director of Nursing did not attend the meeting. The Quality Assurance Performance and Improvement meeting minutes dated 12/9/21 does not include the Administrator's signature or the Medical Director's signature, which would indicate the Administrator and Medical Director did not attend the meeting. On 3/24/22 at 1:40 p.m., Surveyor interviewed Administrator- A in regard to the QAPI quarterly attendance logs. Administrator- A stated that she is not aware why the required attendees were not at the 3/10/21 and 6/9/21 meetings as she was not employed with the facility at this time. Administrator- A stated that for the 9/8/21 meeting the facility had an interim Director of Nursing but is not aware why they did not attend the meeting. Administrator- A stated that she was the Administrator at the time of the 12/9/21 meeting but does not recall why she and the Medical Director did not attend the meeting.

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F 0947 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 16584 Based on interview and record review the Facility did not ensure 5 (CNA-J, CNA-K , CNA-L, CNA-M and CNA- N) of 5 randomly sampled CNAs (Certified Nursing Assistant) who had been employed for over a year received dementia management training. This deficient practice has the potential to affect all 116 Residents. Findings include: On 3/24/22 at 10:30 a.m. Surveyor reviewed in-service records provided by Administrator-A for the five randomly selected CNAs. CNA-J was hired on 7/27/16. CNA-J received abuse training on 1/11/22. The Facility did not provide evidence CNA-J received dementia training. According to Administrator- A, the CNA's are assigned to various units throughout the facility. CNA-K was hired on 6/8/16. CNA-K received abuse training on 1/11/22. The Facility did not provide evidence CNA-K received dementia training. According to Administrator- A, the CNA's are assigned to various units throughout the facility. CNA-L was hired on 12/6/18. CNA-L received abuse training on 1/11/22. The Facility did not provide evidence CNA-L received dementia training. According to Administrator- A, the CNA's are assigned to various units throughout the facility. CNA-M was hired on 7/26/18. CNA-M received abuse training on 1/11/22. The Facility did not provide evidence CNA-M received dementia training. According to Administrator- A, the CNA's are assigned to various units throughout the facility. CNA-N was hired on 10/13/09. CNA-N received abuse training on 1/11/22. The Facility did not provide evidence CNA-N received dementia training. According to Administrator- A, the CNA's are assigned to various units throughout the facility. Surveyor interviewed Administrator- A in regards to the CNA training's. Administrator- A stated that they have not provided the Certified Nursing Assistants with any type of Dementia training and was not aware this was a requirement.