STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525074	A. Building B. Wing	04/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madison Health and Rehabilitation Center	110 Belmont Rd Madison, WI 53714

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30992 Based on interview and record review the facility did not immediately notify the resident representative(s) when there was a significant change in the resident's physical and mental status such as a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications and per resident wishes for 1 of 3 residents (R1) reviewed for notification/change of condition. R1 fell and sustained a fracture to her right great toe. The facility failed to notify R1's Activated Power of Attorney for Healthcare (APOAHC) of the fracture. As evidenced by The facility policy, change in a Resident's Condition or Status, revised May 2017, indicates in part, the following: Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g., changes in the level of care, billing/payments, resident rights, etc.). Policy Interpretation and Implementation: 1. The nurse will notify the resident's Attending Physician or physician on call when there has been a (an): d. significant change in the resident's physical/emotional/mental condition; e. need to alter the resident's medical treatment significantly; g. need to transfer the resident to a hospital/treatment center; specific instructions to notify the Physician of changes in the resident's condition. 4.a.a nurse will notify the resident's representative when: a. The resident is involved in any accident or incident that results in an injury including injuries of an unknown source. R1 was admitted to the facility on [DATE] with diagnoses including, but not limited to, metabolic encephalopathy, diabetes mellitus type 2, chronic kidney disease stage 3, Alzheimer's disease, vascular dementia with behavioral disturbance, lack of coordination, repeated falls, decreased mobility and muscle weakness. R1's MDS (Minimum Data Set) assessment dated [DATE] notes a BIMS (Brief Interview for Mental Status) score of 11/15 indicating R1 is moderately cognitively impaired. R1 has an APOAHC. R1's CNA (Certified Nursing Assistant) Care Card, undated, documents the following: Enc [Encourage] to wear flat shoes when weight bearing, ambulate with 4ww [4 wheeled walker], 1 assist, and w/c [wheelchair] to follow once a day up to 50 feet. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/23/22 at 9:38 PM, R1's fall investigation is documented as follows: Staff heard R1 shouting from dining room opposite her room, staff found resident sitting on the floor next to her walker. Resident stated that she was trying to stand up to go to room, fell back on the chair and slid to the floor, resident denied hitting her head. Immediate Action Taken: R1 was assessed for injuries, has skin tear to left index finger measuring 0.4 x 0.3 cm [centimeters], R1 assisted from the floor via Hoyer lift with 2 staff, neuros initiated and intact, Physician and DON B (Director of Nursing) were updated. Mental State: Oriented to person and place Injuries: None Predisposing Factors: Disease process, using walker On 3/24/22 at 5:56 AM, R1's progress note documents the following: Res [Resident] reported pain on her right foot, on assessment noticed resident has pain to touch at the right great toe of 5/10, noticed color change/dark pallor at the joint between the right great toe and foot, called on call (Physician Assistant) who gave order for STAT x-ray to the right great toe R1's APOAHC was updated. R1's Progress Note dated 3/5/22 at 9:11 AM, indicates the following: IDT [Interdisciplinary Team] met and discussed recent fall with injury. Staff to make sure resident is in a flat soled shoe when weight bearing. Therapy to screen. Will monitor for pain. On 3/24/22 at 3:58 PM, R1's x-ray results indicates the following: Acute displaced fracture base of proximal phalanx great toe. The facility did not notify R1's APOAHC regarding R1's fractured toe. On 4/27/22 at approximately 1:00 PM, Surveyor spoke with DON B (Director of Nursing). Surveyor asked DON B should staff notify a resident's APOAHC when a resident sustains a broken bone from a fall. DON B stated, Yes. DON B stated should R1's APOAHC have been notified of her right fractured toe due to a fall. DON B stated, yes. DON B stated, she cannot find notification of R1's APOAHC regarding the fracture. DON B stated when she obtained R1's x-ray results she notified the NP (Nurse Practitioner) and the RN (Registered Nurse) on duty of the fracture. DON B stated the onus is on her.

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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 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** 30992 Based on observation, interview, and record review, the facility did not ensure that a resident who is unable to carry out the task of personal hygiene independently receives the necessary services to maintain good grooming and personal hygiene for 2 of 4 residents reviewed for ADL's out of a sample of 5 residents (R1 and R5). Evidenced by: R1 was admitted to the facility on [DATE] with diagnoses including, but not limited to, metabolic encephalopathy, diabetes mellitus type 2, chronic kidney disease stage 3, alzheimer's disease, vascular dementia with behavioral disturbance, lack of coordination, repeated falls, decreased mobility and muscle weakness. R1's MDS (Minimum Data Set) assessment dated [DATE] notes a BIMS (Brief Interview for Mental Status) score of 11/15 indicating R1 is moderately cognitively impaired. R1 requires extensive assistance of 1 staff for bathing. R1's CNA (Certified Nursing Assistant) Care Card, undated, documents the following: Showers Tuesday-AM and Friday-AM. R1's Comprehensive Care Plan indicates a Focus: (Date Initiated 10/9/21) Actual Complications with Deficits with ADLs [Activities of Daily Living] R/T [related to] confusion, cellulitis, decreased mobility recent encephalopathy. R1's Activated Power of Attorney for Healthcare (APOAHC) indicated R1 is not receiving ADL care. Surveyor reviewed R1's showers received in the past 30 days. R1's shower documentation is as follows: Friday 4/1: Not received Tuesday 4/5: Completed Friday 4/8: Completed Tuesday 4/12: Not received Friday 4/15: Not received R1 was admitted to the hospital on 4/17/22 and will not return to the facility. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/27/22 at approximately 1:00 PM, Surveyor spoke with DON B (Director of Nursing). Surveyor asked DON B should residents receive showers as scheduled. DON B stated, Yes. Surveyor reviewed the dates R1 did not receive a shower. DON B stated R1 should receive showers as scheduled. DON B stated she has noted there is a systemic issue (end of March 2022) in the facility with ADLs in general and she has started to address these issues. Surveyors noted based on APOAHC interviews and shower sheets that ADL cares are a current concern. 40588 Example 2 R5 was admitted to the facility on [DATE] with diagnosis including, but not limited to: Diabetes Mellitus type II, Asthma, Pulmonary embolism, chronic pain syndrome, and obesity. R5's Admission MDS (Minimum Data Set) assessment indicates she had a BIMS (Brief Interview of Mental Status) Score of 13, indicating she was cognitively intact. This MDS assessment also indicates R5 is totally dependent on staff assistance of one for bathing. R5's Care Plan indicates she has a self-care deficit related to decreased mobility, generalized weakness and requires assistance of one with bathing. On 4/27/22, at 10:52 AM, Surveyor spoke with R5 about showering/bathing in the facility. R5 indicated to Surveyor she believed she had only received two showers and had her hair washed twice since admission to the facility. Surveyor requested documentation of R5's showers received in the past 30 days and was provided a printout noting R5 had only received one shower since 3/29/22, occurring on 4/5/22 PM shift. At the time of survey, R5 had gone 22 days without a shower.

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F 0684 Level of Harm - 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** 30992 Based on interview and medical record review, facility staff did not provide care and treatment in accordance with professional standards of practice for 2 of 3 sampled residents (R1 and R4). R1 was admitted to the facility on [DATE] with diagnoses including, but not limited to: metabolic encephalopathy, diabetes mellitus type 2, chronic kidney disease stage 3, alzheimer's disease, vascular dementia with behavioral disturbance, lack of coordination, repeated falls, decreased mobility and muscle weakness. R1 developed facility acquired ulcerations to her left great toe (12/11/21) and right second toe. The facility was not completing daily diabetic foot checks, a nursing standard of practice, and was unaware of the open area to R1's right second toe. On 4/17/22, R1's Activated Power of Attorney for Healthcare (APOAHC) who is also an Registered Nurse (RN) came to visit her. R1's APOAHC was concerned regarding the dramatic change in R1's mentation and assessed what she believed to be cellulitis and open areas to her bilateral feet. R1's APOAHC shared her concern with RN G (Registered Nurse), the agency nurse on duty. RN G, did not obtain a set of vitals, assess R1, complete an SBAR (Situation, Background, Assessment, Recommendation) for R1's change in condition, notify the Physician or assist with arrangements to transfer R1 to the ED (emergency department). As a result, R1's APOAHC transported R1 to the ED herself. As of 4/27/22, R1 remained hospitalized (10+ days) with diagnoses including osteomyelitis of right foot. R4 has an order for daily dressing changes to a wound. This was not documented as completed on 4 days in March 2022 and on five days during the first 26 days of April 2022, This is evidenced by: The facility policy, Change in a Resident's Condition or Status, revised May 2017, indicates in part, the following: Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g. changes in the level of care, billing/payments, resident rights, etc.). Policy Interpretation and Implementation: 1. The nurse will notify the resident's Attending Physician or physician on call when there has been a (an): d. significant change in the resident's physical/emotional/mental condition; e. need to alter the resident's medical treatment significantly; g. need to transfer the resident to a hospital/treatment center; specific instructions to notify the Physician of changes in the resident's condition. 2. A significant change of condition is a major decline or improvement in the resident's status that: a. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions (is not self-limiting). 3. Prior to notifying the Physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including (for example) information prompted by the Interact SBAR Communication Form. 8. The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. 9. If a significant change in the resident's physical or mental condition occurs, a comprehensive assessment of the resident's condition will be conducted as required by current OBRA (Omnibus Budget Reconciliation Act) regulations governing resident assessments and as outlined in the MDS RAI Instruction Manual. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	According to American Medical Doctors Association - The Society for Post-Acute and Long-Term Care Medicine - Pressure Ulcers - Clinical Practice Guideline - http:// www.amda.com/ tools/ guideline. cfm#pressureulcer .to the extent feasible, caregivers should educate patients about daily foot care (e.g., washing, moisturizing), nail care, and about the importance of avoiding walking barefoot, avoiding foot trauma, and promptly telling a caregiver about foot pain or changes in the appearance of the feet . Treatment of foot problems in patients with diabetes is generally stratified into three broad risk categories: at-risk foot; current mild foot, ankle, or heel infection or ulcer; and limb-threatening foot, ankle, or heel infection or ulcer . Risk Category: At-risk foot (patients who smoke; have vascular insufficiency, neuropathy, retinopathy, nephropathy, history of ulcers or amputations, structural deformities, infections, skin/nail abnormality; are on anticoagulation therapy; cannot see, feel, or reach their feet.) Treatment Plan: Refer for podiatric care at least annually and as needed for specific foot problems Train caregivers to perform daily foot care and inspection To the extent feasible, train patients to perform daily foot care and inspection . R1 was admitted to the facility on [DATE] with diagnoses including, but not limited to, metabolic encephalopathy, diabetes mellitus type 2, chronic kidney disease stage 3, alzheimer's disease, vascular dementia with behavioral disturbance, lack of coordination, repeated falls, decreased mobility and muscle weakness. R1's Admission Skin assessment dated [DATE] indicates R1 does not have any skin integrity concerns. R1's MDS (Minimum Data Set) assessment dated [DATE] notes a BIMS (Brief Interview for Mental Status) score of 11/15 indicating R1 is moderately cognitively impaired. Section M (Skin), indicates R1 has no ulcers, wounds, or skin problems. R1's Comprehensive Care Plan includes in part: (Date Initiated: 10/9/21) At risk for complications with cognitive status r/t [related to] Alzheimer's and Vascular Dementia; Goal: Will make simple decisions regarding activities of daily living through next review date. Interventions: .Observe for a change in condition - level alertness, confusion, forgetfullness, reorient as needed, determine of able to reorient. Review changes with MD/NP (Medical Doctor/Nurse Practitioner). (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Skin Integrity: (Date Initiated: 10/9/21) At risk / and/or Potential for Complications with impaired skin integrity AND/OR pressure R/T [related to] Decreased mobility, incontinent of B/B [bowel/bladder]; 12/21.21 - left great toe diabetic wound; Interventions: Assist as needed to reposition Q2 [every 2 hours] in bed an chair and PRN [as needed]; Follow facility skin protocol; .Observe skin with AM/PM cares and with toileting for redness, rashes, open areas, pain, swelling and report to team leader, weekly skin check. Lotion to dry skin. Review skin problems with MD. Treatments as ordered; Pressure reduction cushion in in W/C [wheelchair]; Pressure reduction mattress on bed; Observe skin during cares and report alterations in skin integrity to the nurse. R1's Physician orders, signed 4/4/22, indicate the following: (Start Date: 2/17/22) Monitor LLE [left lower extremity] for signs/symptoms of infection/cellulitis with noted erythema on LLE. Update NP (Nurse Practitioner) if further symptoms present every shift for cellulitis. It is important to note, the facility is not completing nor documenting daily diabetic foot checks for R1. Daily diabetic foot checks are a nursing standard of practice that could have led the facility to identify R1's skin integrity issues timely. On 4/17/22 at 2:30 PM, R1's Progress Notes indicates the following: Resident's family came, they were horrified of the condition there [sic] mother was in. Toes bilaterally presented with narcotic [sic]) (necrotic) injuries and left leg has severe cellulitis. Family stated they will not be bringing mother (R1) back. Resident was going to hospital left at 2:30 PM. It is important to note, the agency RN on duty did not obtain a set of vitals, assess R1, complete an SBAR (Situation, Background, Assessment, Recommendation) for R1's change in condition, notify the Physician, or assist with arrangements to transfer R1 to the ED (emergency department). This agency RN no longer works at the facility. On 4/17/22, R1's ED (emergency department) notes document the following: Patient is an [AGE] year-old female with history of dementia, diabetes mellitus, osteomyelitis of the left great toe, and recurrent Cutis [urinary tract infections] who presents with a chief complaint of left lower extremity erythema. Based on history provided primarily by patient's daughter, she went to visit her today and found her to be more confused than baseline. Patient's daughter states she had a normal conversation with her approximately 1 week ago but today she appeared to be agitated, presenting similarly to prior episodes where she has had underlying infection. Patient's daughter noted she had significant erythema to her left calf. There has been no reported fevers, falls, diarrhea, vomiting from the care facility. Patient's daughter also expresses concern about patient's hygiene at her current care facility. She presented to the emergency department today for further workup. On arrival, patient frequently stating I'm scared, unable to provide any additional history. Based on chart review, patient was recently admitted in January where she was noted to have evidence of a left great toe osteomyelitis as well as Klebsiella UTI [urinary tract infection] and MRSA [Methicillin-Resistant Staphylococcus Aureus] bacteremia. Physical Exam: .Skin: Warm and dry. Ulceration present to the left great toe and right 2nd toe. Erythema without purulence or induration to the left calf, warm to touch. Final Impression: Left lower extremity cellulitis, altered mental status, osteomyelitis of the left great toe and right 2nd toe. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Labs show elevation of CRP (C-Reactive Protein) [A high CRP test results can be a sign of acute inflammation. It may be due to serious infection, injury or chronic disease] and ESR (Erythrocyte Seimentation Rate) [An increased ESR ate may be due to an infection]. Procalcitonin is negative. Lactate is normal. Patient with cellulitis to left lower extremity. X-rays also concerning for possible osteomyelitis. Given patient's concern for cellulitis with history MRSA was given a dose of vancomycin. Patient with mental status changes concern for more systemic infection. Patient admitted to hospital for further workup and management. R1 was transferred to a different hospital with a Podiatry Unit. The second hospital documented the following: .Daughter noted cellulitis of both legs L>R [left greater than right] when she went to visit her today. Pt [sic] [patient] also thought pt more confused and agitated and is not care for correctly at SNF [Skilled Nursing Facility]. Per daughter she last saw R1 on 4/3/22 and R1 was able to have conversation and had no redness. Today pt was agitated and screaming out intermittently. X-ray results: Right Foot: Impression: Intrac-articular fracture of the base of the proximal phalanx of the great toe, possibly acute 2. Near complete resorption of the distal phalanx of the second toe with surrounding soft tissue irregularity. ***These finings are concerning for osteomyelitis. Left Foot: Indication: Left great toe lesion; Impression: Unchanged appearance of the distal phalanx of the great toe, with no definite new areas of erosion or periosteal reaction. It is important to note, the facility was unaware of any open area to R1's right toes/foot. In addition, the facility was not completing, nor documenting daily diabetic foot checks for R1. As of 4/27/22, the date of this complaint investigation, R1 remains hospitalized (10+ days) while continuing to receive IV (intravenous) Vancomycin and oral antibiotics. On 4/27/22 at 12:38 PM, Surveyor spoke with RN C (Registered Nurse) who is the Wound Care Nurse. RN C is not WCC (Wound Care Certified). Surveyor asked RN C when is the last time she saw R1's toes. RN C stated she last saw R1's left foot/toes on 4/11/22 when she rounded with the physician. RN C stated R1's wound had no necrotic tissue and neither did her toes. Surveyor asked RN C were you aware of any open areas to R1's right foot/toes. RN C stated, No. Surveyor asked RN C, if staff note a new open area what should they do. RN C stated staff should alert the floor nurse. The floor nurse should complete an assessment and if RN C is in the building, staff notify her so she can complete an assessment. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 4/27/22 at approximately 12:50 PM and 3:05 PM, Surveyor spoke with DON B (Director of Nursing). DON B stated that RN G (Registered Nurse) was terminated. DON B stated, RN G wrote about R1 having cellulitis; however, she had no means to determine cellulitis. DON B stated she told her to put it in quotes so it does not look like she's diagnosing. Surveyor asked DON B were daily diabetic foot checks completed and documented for R1. DON B stated, I could not find daily diabetic foot checks. Surveyor asked DON B should the facility have been completing daily diabetic foot checks for R1. DON B stated, Yes. Surveyor asked DON B, would you expect the facility to have been aware of open areas to R1's foot? DON B stated, yes. Surveyor asked DON B would you expect the facility to identify a change in condition DON B stated, yes. Survyeor asked DON B, when R1's APOAHC brought concerns regarding cellulitis to RN G's attention, would you have expected her obtains vitals, complete an assessment/document an SBAR, notify the Physician, and assist with arrangement to transfer R1 to the ED. DON B stated, yes, RN G should have completed each of these steps. 40588 Example 2 R4's initial admission to the facility was on 1/31/22 with diagnoses including, but not limited to, Acute embolism and thrombosis of right iliac vein, infection following a procedure, superficial incisional surgical site. R4's BIMS (Brief Interview of Mental Status) Score on the Minimum Data Set completed 3/1/22 was 14, indicating R4 is cognitively intact. On 4/27/22, at 10:21 AM, Surveyor spoke with R4 regarding wound care for her right hip. R4 indicated she is supposed to have a daily dressing change on the PM shift, but stated, It doesn't always get done. R4 stated her dressing did not get changed last weekend. R4 acknowledged there have been times she has chosen not to have it done until the next day, but also stated, I know there are staffing struggles. I don't like new nurses who've never done my dressing before. There have been times when the nurse still hasn't come in to change it and it is after 9:30 (PM), so I sometimes say forget it. Surveyor reviewed R4's Treatment Administration Record (TAR) and Nurse's Notes. - In March 2022, according to the TAR, R4 did not receive wound treatment on four occasions (3/9, 3/18, 3/25, and 3/29) with no supporting documentation to indicate why it was not completed or with an update to the provider to inform of the missed treatment. - In April 2022 (through 4/26/22), according to the TAR, R4 did not receive wound treatment on five occasions (4/1, 4/5, 4/11, 4/12, 4/24) with no supporting documentation to indicate why it was not completed or with an update to the provider to inform of the missed treatment. On 4/27/22, at 1:30 PM, Surveyor spoke with RN D (Registered Nurse) and asked if R4 ever refused treatments. RN D indicated R4 never refused cares and stated, I wish they were all like her. Surveyor asked RN D what steps she would take if R4 did refuse or miss a scheduled treatment, and RN D stated she would document the reason and pass it on to the next shift to have it completed then. RN D stated she would also contact the provider if it was a big concern. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 4/27/22, at 1:46 PM, Surveyor spoke with DON B (Director of Nursing) regarding wound treatments and asked if she expects treatments to be completed as ordered. DON B stated, Yes. Surveyor asked if a treatment is not signed out as completed and there is a blank box on the TAR, is it assumed the treatment was not done? DON B replied, Yes. Surveyor asked if a resident refused a treatment or there was an extenuating circumstance, would DON B expect a nurse's note to explain, and she stated, Yes.

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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** 40588 Based on observation, interview, and record review, the facility did not implement professional standards of practice to ensure a resident does not develop pressure injuries (PIs), receives necessary treatment and services to promote healing of PIs, or prevent new PIs from developing for 1 of 3 Residents sampled for PIs (R5). - R5 developed a PI in the facility, which was not discovered until it was a stage 3. After discovery, the facility did not update the care plan until 18 days later. The facility did not follow wound care treatment as ordered and did not reposition R5 as often as would be indicated. This is evidenced by: The facility policy titled, Wound Care, from MED-PASS, Inc, last revised October 2010, which states, The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. The policy reads, in part . Preparation; 1. Verify that there is a physician's order for this procedure. 2. Review the resident's care plan to assess for any special needs of the resident. A. For example, the resident may have PRN (as needed) orders for pain medication to be administered prior to would [sic] care. The policy indicates the following should be recorded in the resident's medical record: 1. The type of wound care given. 2. The date and time the wound care was given. 3. The position in which the resident was placed. 4. The name and title of the individual performing the wound care. 5. Any change in the resident's condition. 6. All assessment date (i.e., wound bed color, size, drainage, etc. obtained when inspecting the wound. 7. How the resident tolerated the procedure. 8. Any problems or complaints made by the resident related to the procedure. 9. If the resident refused the treatment and the reason(s) why. 10. The signature and title of the person recording the data. The policy reads as follows regarding reporting on wounds, 1. Notify the supervisor if the resident refuses the wound care. 2. Report other information in accordance with facility policy and professional standards of practice. R5 was admitted to the facility on [DATE] with diagnoses including, but not limited to: Diabetes Mellitus type II, Asthma, Pulmonary embolism, chronic pain syndrome, and obesity. R5's Admission MDS (Minimum Data Set) assessment indicates she had a BIMS (Brief Interview of Mental Status) Score of 13, indicating she was cognitively intact. R5's Admission MDS also indicated in Section M regarding skin, she was admitted to the facility at risk of developing PIs, but on admission did not have any unhealed PIs. R5's Care Plan for skin integrity which was initiated on 3/26/22 and revised on 4/25/22 reads: - Focus o Resident has actual impaired skin integrity r/t [related to]: decreased mobility, Diabetes, Pain - preventing active movement. - Goal (continued on next page)

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	525074	A. Building B. Wing	04/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madison Health and Rehabilitation Center	110 Belmont Rd Madison, WI 53714

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F 0686 Level of Harm - Actual harm Residents Affected - Few	o The Resident skin will remain intact and remain free of irritation, redness, blisters, discoloration, etc. through next review date. - Interventions/Tasks o Wound RN and wound MD as ordered (Date initiated 4/25/22) o Assist to reposition approximately q [every] 2-3 hours and prn (date initiated 3/26/22) o Complete Braden scale upon admission, weekly x4, quarterly, with SCOC [sudden change of condition] and prn (date initiated 3/26/22) o Lotion skin with cares (date initiated 3/26/22) o Weekly skin assessment (date initiated 3/26/22) o Pressure redistribution mattress (date initiated 3/26/22) o Monitor skin with all cares. Report any changes to nurse (date initiated 3/26/22) o Update MD PRN (date initiated 3/26/22) o Refer to RD PRN (date initiated 3/26/22) o Refer to therapy PRN (date initiated 3/26/22) On 4/7/22, the facility document Weekly Wound Assessment shows R5's PI on right buttock measured 1.2 cm x 0.9 cm x 0.1 cm and was documented as a Stage III. Other notes in the assessment indicate the wound is 100% granulation, no abnormalities to the wound edges, no exudate is indicated but serosanguinous [sic] is checked, no odor, physician has been notified, wound progress is stable, treatments that apply include turning and repositioning and wound treatment/application of dressing, no pain associated with the wound, and pain management is Tylenol as needed. Other comments indicate, Current treatment: Right buttocks, cleans with NS [Normal Saline], apply skin prep to peri-wound, cover with foam dressing, change every 3 days and PRN. This wound assessment is signed by RN C (Registered Nurse) on 4/19/22. *Note - R5's PI was discovered on 4/7/22 and there were no changes to her care plan or new care plan interventions initiated until 4/25/22, when wound RN and wound MD as ordered was added. On 4/11/22, an identical facility document of R5's Weekly Wound Assessment was completed with the only difference being the wound measurement date and onset date of treatment both reading 4/11/22 (not 4/7/22) and signed by RN C on 4/19/22. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 4/18/22, the facility document Weekly Wound Assessment indicates R5's PI on right buttock measured 1. 08 cm x 1.10 cm x 0.1 cm and was documented as a Stage III. Other notes in the assessment indicate the wound is 100% granulation, no abnormalities to the wound edges, a moderate amount of exudate which was marked as Serous, no odor, stable, onset date of treatment of 4/11/22, treatments that apply are marked as turning and repositioning and wound treatment/application of dressing, wound clinic/wound physician consultation. The assessment indicates the treatment has changed in the past two weeks on 4/18/22. No pain associated with the wound, with Tylenol as needed for pain management. Other comments indicate, Current treatment Right & Left buttocks, cleans wound with saline, protect periwound with Skin Prep, Cover wound with Foam, Change MWF [Monday, Wednesday, Friday], Change PRN for soiling and/or saturation. Signed by RN C on 4/19/22. Surveyor requested wound clinic/wound physician documentation and was provided with partial documentation. The following was provided to Surveyor: 1. R5 Wound Evaluation Page 1 of 4 and 2 of 4 dated 4/18/22, Location: Left buttock; Wound ID: 7972. o Measurements: Length: 0.81 cm, Width: 0.55 cm, LxW: 0.45 cm2, Depth: 0.10 cm, Total: 0.29 cm2 o Observations: Depth [cm]: 0.10; Etiology: Trauma; Margin Detail: Attached edges; Wound bed Assessment: Early/Partial granulation; Drain amount: Moderate; Moderate; Drain description: Serous; Odor; Normal Odor; Periwound: Clean, dry, intact. o Orders: Wound cleansing and Dressing: Cleanse wound with saline, protect periwound with skin Prep, Cover with Foam, Change MWF, Change PRN for soiling and/or saturation Nutrition: Discussed nutrition and its impact on wound healing o Plan of Care: Plan of Care discussed with Facility Staff 2. R5 Wound Evaluation Page 1 of 6 and 2 of 6 dated 4/25/22, Location: Right buttock; Wound ID: 7971 o Measurements: None listed o Observations: Depth (cm): 0.10; Etiology: Pressure Ulcer - Stage 3; Margin Detail: Attached edges; Wound bed Assessment: Fully Granulated; Drain amount: Moderate; Drain Description: Serous; Odor: Normal Odor; Periwound: clean, dry, intact. o Orders: Wound Cleansing and Dressing: Cleanse wound with saline, protect periwound with skin Prep, Cover wound with Foam, Change MWF, Change PRN for soiling and/or saturation Nutrition: Discussed nutrition and its impact on wound healing (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	o Plan of Care: Plan of Care discussed with Facility Staff Review of R5's Treatment Administration Record (TAR) shows the following: - Start date - 4/7/22: Apply mepilex dressing to right buttock wound one time only for 1 day. This order is signed out as completed. - Start date - 4/12/22, D/C date 4/18/22: Wound care: Right buttocks, cleanse with NS, apply skin prep to peri-wound, cover with foam dressing, change every 3 days and PRN. This order was not signed out as completed until 4/15/22. Also note, this order was charted as the current treatment on the facility Weekly Wound Assessment documentation but was not on the TAR. - Start date - 4/20/22: Wound care: Right and Left buttocks, Cleanse wound with saline, protect periwound with Skin Prep, Cover wound with Foam, Change MWF, Change PRN for soiling and/or saturation. This order was not signed out as completed on the TAR on 4/20/22 or 4/22/22. The first time this order was documented as completed on the TAR was 4/25/22. On 4/27/22, at 10:20 AM, Surveyor observed R5 being assisted with morning cares and transferring out of bed. On 4/27/22, at 10:52 AM, Surveyor spoke with R5 and asked if she had any current open areas or skin concerns. R5 indicated she had something on my bottom. Surveyor asked if nursing was doing dressing changes or if the treatment she was to get was being done when it was supposed to be done. R5 indicated nursing was doing it, but she wasn't sure if it was being done when it was supposed to be done. On 4/27, at 3:44 PM, Surveyor spoke to R5 again while waiting for staff to return to R5's room with stand lift. Surveyor observed R5 sitting in wheelchair in the same location as this morning when interviewed. Surveyor asked R5 if she had been toileted since breakfast or been off her bottom at all. R5 stated she had not used the restroom and stated, I have not used the commode at all yet. On 4/27/22, at 3:49 PM, Surveyor observed staff complete a dressing change to R5's left and right buttock with LPN E (Licensed Practical Nurse) and CNA F (Certified Nursing Assistant). LPN E and CNA F assisted R5 from her chair to her bed with a standing lift. While R5 was standing in the lift next to her bed and her pants were taken down, a large amount of serosanguineous drainage was visible on the outside of R5's incontinent brief. R5 was assisted into bed and LPN E asked R5 if she had any pain in her bottom. R5 stated, Yeah, and LPN E said, I'll get you something for that. R5 then mentioned she has stayed up in her wheelchair longer than this before, saying, I've stayed up longer. What was it, 9:00 that one night? LPN E and CNA F assisted R5 to turn and removed incontinent brief, revealing several small, shallow open areas on both left and right buttocks. Surveyor felt the areas presented as Stage II pressure. No dressing was observed on R5's skin or attached to the incontinent pad. Surveyor asked LPN E if there was a dressing that had fallen off with the removal of the pad, and LPN E said, No. Surveyor asked R5 if she knew when the dressing was last changed or when it might have been removed or fallen off, but R5 could not recall. On 4/27/22, at 1:30 PM, Surveyor spoke with RN D an asked if R5 ever tended to refuse cares or wound treatment. RN D indicated R5 never refused. RN D stated if a resident does refuse, she would document the reason and pass it on to the next shift to have it completed then. RN D stated she would also contact the provider if it was a big concern. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 4/27/22, at 1:46 PM, Surveyor spoke with DON B (Director of Nursing) regarding wound treatments and asked if she expects treatments to be completed as ordered. DON B stated, Yes. Surveyor asked if a treatment is not signed out as completed and there is a blank box on the TAR, is it assumed the treatment was not done? DON B replied, Yes. Surveyor asked if a resident refused a treatment or there was an extenuating circumstance, would DON B expect a nurse's note to explain, and she stated, Yes. The facility did not ensure a resident who was at risk for Pressure Injury development did not develop a PI. Once this resident did develop a PI (4/7/22), the facility did not implement any changes in the resident's Care Plan until 4/25/22 and did not perform treatments as ordered.