STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525547	A. Building B. Wing	07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glendale Care and Rehab Center LLC	6263 N Green Bay Ave Glendale, WI 53209

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	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35720 Based on observation, interview, and record review the facility did not provide care and treatment for the promotion of preventing pressure injuries and promoting the healing of existing pressure injuries for 5 (R48, R62, R66, R64, and R8) of 8 sampled residents. -R48 was at risk for the development of pressure injuries. The facility did not put interventions in place to offload pressure to R48's heels prior to R48 developing a pressure injury that developed necrotic tissue. -R62 was at risk for the development of pressure injuries. The facility did not put interventions in place to offload pressure to R62's heels following R62 having a fracture to their left femur. R62 developed an unstageable pressure injury to the left heel. The facility stated R62 refused offloading measures to his heel, but did not develop a plan of to address R62's refusals. -R66 has an unstageable pressure injury. R66 had a physician order for a treatment change that was not updated and carried out as ordered by the physician. R66's care plan of care did not include offloading interventions. -R64 is at risk for the development of pressure injuries. R64 was observed with their heels not offloaded. -R8 was admitted to the facility with pressure injuries and was observed not being turned and repositioned per their plan of care. The examples involving R48 and R62 are being cited at the scope and severity of a G (actual harm/isolated). Findings include: 1.) R48 has diagnoses that include type 2 diabetes mellitus, multiple sclerosis, moderate protein-calorie malnutrition, lack of coordination, difficulty in walking, abnormal posture, cognitive communication deficit, major depressive disorder, muscle weakness, and hypertension. A Braden Assessment on 5/1/21 scores R48 as 14 indicating R48 at being moderate risk for the development of pressure injury. The assessment documents R48's mobility as being slightly limited, chairfast, and nutrition as very poor. (continued on next page)

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

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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R48's quarterly MDS (minimum data set assessment), with an assessment reference date of 6/30/21 documents R48 requiring extensive assistance of 1 person's physical assist for bed mobility and rejection of care behavior was not exhibited during the assessment reference period. The assessment documents R48 having a brief interview for mental status score of 0 indicating 48 is severely cognitively impaired. The assessment documents R48 as being at risk for the development of pressure injuries. R48's plan of care includes a focus area for At moderate risk for skin integrity Score on Braden assessment for pressure Ulcers, CVA [cerebrovascular accident], Diabetes, Mellitus, Incontinence (B/B) [bowel/bladder], Weakness. Initiated on 10/28/2019 and revised on 4/29/20. The care plan includes interventions for Skin checks weekly when changing clothes, bathing, showering revised on 6/30/21 from previously being skin checks 2x week when changing clothes, bathing, showering and positions self revised on 6/11/20. Progress notes on 7/6/2021 at 6:18 am document resident bilateral heels is [sic] purplish in color and mushy, left message for [granddaughter] and [case manager] to returned [sic] call. A Wound Assessment on 7/6/2021 at 7:49 am documents a 5 cm x 6 cm deep tissue pressure injury to R48's right heel. A wound assessment note on 7/6/2021 at 9:05 am by Wound RN (registered nurse)-C documents .found on resident cares DTI [deep tissue injury] to right heel area is soft when palpated sero purulent drainage expressed slight depression where callused had been present peri wound dry and flaking: Medical history: CVA diabetes encephalopathy MS [multiple sclerosis], depression, HTN [hypertension], resident has been declining in health; supplements in place off loading boots in place. MD and POA [power of attorney] updated. Progress notes on 7/6/2021 at 8:42 am document [Contact] updated on wounds, goals of care discussed, air mattress ordered, heel boots worn at this time. On 7/6/2021 R48's plan of care was updated to include a focus area for The resident has pressure injury left heel for potential for pressure ulcer development r/t [related to] disease process, Immobility. The care plan was revised on 7/7/2021 to The resident has pressure injury right heel or potential for pressure ulcer development r/t disease process, Immobility. Interventions include off loading boots at all times, Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate initiated on 7/6/2021 and air mattress initiated on 7/7/2021. The surveyor noted prior to 7/6/2021 R48's plan of care did not include interventions to offload R48's heels and that R48 required extensive assistance for bed mobility. On 7/12/2021 a wound assessment documents R48's wound as being a deep tissue pressure injury 60% necrotic hard firm adherent tissue and 40% blood filled blister. A wound assessment note by Wound RN-C documents .area is forming hard eschar. Further area of the wound bed still appears discolored and boggy Medical history: CVA diabetes encephalopathy MS depression HTN, resident has been declining in health; supplements in place off loading boots in place. On 7/13/2021 at 7:54 AM the surveyor observed Wound RN-C perform wound care on R48. The surveyor observed R48 in a wheelchair and Wound RN-C lifted her foot, removed R48's offloading boot, and applied betadine. The surveyor observed Wound RN-C lift R48's foot and noted R48 did not help hold up her own foot. The surveyor observed R48's right heel to be black in color (eschar). (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	On 7/13/2021 at 11:09 AM the surveyor interviewed Wound RN-C. The surveyor asked who developed care plans. Wound RN-C stated the MDS nurse makes a blanket one, and she was putting into that care plan when someone was admitted , or when they developed an area so if at risk interventions are in place such as given on their bed mobility if someone needs an air mattress or immobile need heels boated or boots on. The surveyor asked how it is determined in someone needs boots or heels offloaded to offload pressure from their heels. Wound RN-C stated based on their braden or bed mobility. The surveyor informed Wound RN-C of being unable to find interventions to offload pressure from R48's heels prior to her developing a pressure injury to her right heel. Wound RN-C stated she knew for R48 it wasn't put into place prior to the area developing. Wound RN-C stated it was one of those things, she just all of a sudden had this big blister. Wound RN-C stated R48 was still able to move and wearing shoes which now looking back probably wasn't the best thing. Wound RN-C stated she wasn't notified of discoloration prior to the big blister. The surveyor informed Wound RN-C of R48's care plan indicating she positions self, and R48's MDS indicating R48 required extensive assistance for bed mobility and requiring assistance with positioning during the survey. Wound RN-C informed the surveyor she did not develop R48's at risk pressure injury care plan. Wound RN-C stated during the last 3 and a half/ 4 months R48 has slowed down, some days she is better, and that today when she went to look at the heel it was difficult, she has had up days and down, hasn't had a steady decline, and that she believed it was a progression of R48's MS. The surveyor asked when care plans are reviewed. Wound RN-C stated quarterly and after she sees a residents' wounds. Wound RN-C stated she R48 did not have any issues until recently, R48 wasn't having any skin issues, wasn't eating much but was getting supplements, and was doing increased skin assessments. Wound RN-C stated R48 went to not having issues to having a big blister on her foot. On 7/13/2021 at 1:01 PM the surveyor informed NHA (nursing home administrator)-A and DON-B of concern related to R48 being at risk for the development of pressure injuries with no interventions in place to offload her heels prior to the development of a pressure injury with necrotic tissue. NHA-A stated R48 used to be up and walk and has had a recent decline. On 7/13/2021 at 2:17 PM NHA-A provided the surveyor with a doppler report completed on 7/8/21 indicating R48 has mild to moderate peripheral vascular disease changes. 2.) R62 has diagnoses that include fracture of left femur, lack of coordination, abnormal posture, protein calorie malnutrition, weakness, altered mental status, dementia, chronic kidney disease, parkinson's disease, peripheral venous insufficiency, atrial fibrillation, hypertension, and mild cognitive impairment. R62's Braden Risk assessment for predicting pressure ulcer risk on 4/1/21 documents R62 at being at risk for the development of pressure injuries scoring 18 R62's Braden Risk assessment for predicting pressure ulcer risk on 6/28/21 documents R62 at being at increased risk with an increased score of 16 indicating R62 is chairfast, and his mobility as slightly limited. R62's quarterly MDS (Minimum Data Set) Assessment, with an assessment reference date of 6/18/21 documents rejection of care behavior occurred 1 to 3 days during the 7 day look back period, R62 required extensive assistance of one person's physical assistance with bed mobility, was at risk for the development of pressure injuries, and does not indicate a turning/repositioning program was in place. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R62's plan of care includes a focus area for At moderate risk for skin integrity Score on Braden Assessment for Pressure Ulcers, Decrease in cognition, Incontinence (B/B) [bowel/bladder], Weakness, venous insufficiency initiated on 11/12/19 and most recently revised 6/22/21. The surveyor noted R62's plan of care did not include interventions to offload his heels of pressure or how and when staff should assist R62 with repositioning. R62's plan of care includes a focus area for [R62] is resistive to care r/t [related to] Not wanting to turn down music, refusing to use assistive device i.e. [NAME] or wheelchair. [R62] will barricade door to room. Resident will remove foley drainage bag and connect to leg bag, and pull strap tight, will refuse to have staff help initiated on 5/5/21 and most recently revised 5/11/21. The surveyor noted the plan of care does not indicate R62 has refusals to offloading measure of his heels or repositioning. R62's plan of care also includes a focus area for Alteration in skin integrity- resident has a venous stasis ulcer with partial/with swelling and dark discoloration of outer aspect of left lower leg 6/16/2021: intact, clear, fluid filled blister left heel initiated on 10/19/20 and most recently revised 6/22/21. Interventions include Elevate extremity initiated 10/19/20. R62's CNA (certified nursing assistant) Care Card, dated 7/12/21, documents Does not use call light or always make needs known, staff to anticipate needs and left heel wound, no shoe to left foot, gripper sock only. The Care Care does not instruct staff for offloading measures heels or to use a pressure relieving boot. On 5/21/21 R62 was seen by Wound Physician-L for venous ulcers to his bilateral lower extremities. Under Orders for Pressure Relief/Offloading the physician orders include Offload heels per Facility Policy/Protocol. On 6/11/21 R62 was readmitted to the facility following a hospitalization for a left femur fracture. Progress notes on 6/16/21 document While doing ordered wound treatment to left leg writer noted a clear, fluid filled intact blister to left heel. Area difficult to measure due to resident asking writer to stop several times. Education provided to resident not to ambulate without assist and elevate lower extremities . On 6/17/21 a wound assessment note documents a 7 cm x 5.5 cm blood filled blister to R62's left heel. Wounds notes on 6/17/21 by Wound RN (registered nurse)-C documents . large fluid filled DTI [deep tissue injury] painful to the touch resident leg still edematous post fracture and was wearing shoes causing increase pressure . Resident educated he will be unable to wear shoes until swelling goes down and area heals Medical History: intellectual disabilities acute kidney failure, A FIB [atrial fibrillation] HTN [hypertension] chronic Foley d/t [due to]Parkinson's , PVD[peripheral vascular disease], lymphedema ascites stasis dermatitis supplements in place (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 6/18/21 R62 was seen by Wound Physician-L who documents R62 as having a 5.29 cm x 5.59 cm suspected deep tissue injury to the left heel. Under orders for Pressure Relief/Offloading states Offload heels per Facility Policy/Protocol. On 6/22/21 the wound is documented as being 7 cm x 5.5 cm 100% deep maroon. On 6/25/21 R62 was seen by Wound Physician-L Who documents R62' s wound as being unstageable. Under orders for Pressure Relief/Offloading states Offload heels per Facility Policy/Protocol. On 6/28/21 the wound is documented as being unstageable 3.5 cm x 3.5 cm with 100% soft-adherent necrotic tissue. On 7/5/21 the wound is documented as being unstageable 3.5 cm x 3.5 cm with 100% soft necrotic tissue. On 7/9/21 Wound physician L documents R62's wound as being unstageable. Under orders for Pressure Relief/Offloading states Offload heels per Facility Policy/Protocol. On 7/12/21 the wound is documented as being 3 cm x 3.5 cm 20% bright pink or red tissue and 80% soft adherent necrotic tissue. On 7/7/21 at 12:10 PM the surveyor observed R62 in the hallway in his wheelchair with grey gripper socks on both feet, with his feet resting on the wheelchair foot pedals. On 7/7/21 at 1:22 PM the surveyor observed R62 in his wheelchair with grey gripper socks on both feet, with his feet resting on the wheelchair [NAME] pedals. On 7/7/21 at 8:37 AM the surveyor observed R62 in bed on his back, with his heels resting on the mattress, not offloaded or pressure. The surveyor asked R62 if he ever wears boots or puts a pillow under his feet to relieve pressure. R62 stated sometimes. On 7/12/21 at 9:27 AM the surveyor observed R62 in his wheelchair with gripper socks on both feet. On 7/12/21 at 10:26 AM, 12:14 PM, and 3:42 PM the surveyor observed R62 in his wheelchair with a boot on his left foot and a shoe on his right foot. On 7/13/21 at 9:03 AM the surveyor observed R62 sitting at the edge of his bed with gauze wrapper around both feet and with no boots on. On 7/13/21 at 12:37 PM the surveyor interviewed CNA (certified nursing assistant)-K. The surveyor asked if R62 wears boots. CNA-K stated she thought R62 only wore his boots in his bed, and that she was not aware of him refusing his boots. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 7/13/2021 at 11:09 AM the surveyor interviewed Wound RN-C. The surveyor asked who developed care plans. Wound RN-C stated the MDS nurse makes a blanket one, and she was putting into that care plan when someone was admitted , or when they developed an area so if at risk interventions are in place such as given on their bed mobility if someone needs an air mattress or immobile need heels boated or boots on. The surveyor asked how it is determined in someone needs boots or heels offloaded to offload pressure from their heels. Wound RN-C stated based on their Braden or bed mobility. The surveyor asked if R62 was supposed to have pressure relieving boots on. Wound RN-C stated no, R62 refuses. Wound RN-C stated R62 had wanted to wear shoes despite having edema, and has an intellection disability delay, and can get upset if he fixates on something. Wound RN-C stated he had been agreeable to having a pillow in bed and occasionally will agree to a boot. Wound RN-C states some days he will agree and other days gets angry about it and it is not worth upsetting him. On 7/13/21 at 12:57 PM the surveyor interviewed NHA (Nursing Home Administrator)-A and DON (Director of Nursing)-B. The surveyor informed NHA-A and DON-B of the concern related to R62 being at risk for the development of pressure injuries with no interventions in place to offload his heels following a fracture to his left leg and developing an unstageable pressure injury, and no care plan to address his refusals for offloading measures to his heels. DON-B stated the biggest thing for R62 was his continuing to want to wear shoes and updating his care card not to wear shoes and finally able to get him to do that. DON-B stated R62 moves around on his own, for example to the edge of the bed, without calling for staff assistance so also for him worries about boots being unsafe for him. DOB-B stated R62 refuses boots and offloading measures. The surveyor informed NHA-A and DON-B of the observation of R62 in bed and his wheelchair without offloading of pressure to heel occurring and of R62 being observed with a boot on to his lower extremity. 36161 3.) R66 was readmitted to the facility on [DATE] with a diagnosis that included Diabetes Mellitus Type II, Hypertension, Impulse Disorder and Gout. R66's Annual MDS (Minimum Data Set) dated 6/16/21, documents a BIMS (Brief Interview for Mental Status) score of 13, indicating that R66 is cognitively intact. Section G (Functional Status) documents that R66 requires extensive assistance and a two person physical assist for his bed mobility and transfer needs. Section G0400 (Functional Limitation in Range of Motion) documents that R66 has impairment to both sides of his upper and lower extremities. Section M (Skin Conditions) documents that R66 was admitted to the facility with 2 unstageable pressure injuries. Section M also documents that R66 is at risk for the development of pressure injuries. R66's Pressure Ulcer/Injury CAA (Care Area Assessment) dated 6/16/21 documents under the Analysis of Findings section, Alteration in skin integrity-Resident has a ulcer with partial/ full thickness with swelling and dark discoloration of greater aspect of left lower leg. R66's Braden Scale for Predicting Pressure Sore/Injury assessment dated [DATE] documents a score of 14, indicating that R66 is at moderate risk for the development of pressure injuries. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R66's most recent Right Heel Wound Summary assessment dated [DATE] documents, Status: Active; Clinical Stage: Unstageable; Tissue Types: Necrotic Hard, Firm, Adherent-100%; Infection Present: Unable to determine; Exudate: None; Length: 6.00 cm (centimeters); Width: 9.00 cm; Depth: Unknown. R66's most recent Left Heel Wound Summary assessment dated [DATE] documents, Status: Active; Clinical Stage: Unstageable; Tissue Types: Necrotic Hard, Firm, Adherent-100%; Infection Present: Unable to determine; Exudate: None; Length: 6.50 cm (centimeters); Width: 8.00 cm; Depth: Unknown. Surveyor noted that R66's unstageable heel pressure injuries were improving since admission to the facility. Surveyor noted a decrease in the size of the wounds, weekly assessments with measurements and wound bed descriptions, physician notification and following of the wounds by a wound physician. R66's Tissue Analytics Wound Evaluation dated 6/18/21 documents, Location: Left Heel; Measurements: Length-1.98 cm (centimeters), Width: 5.62 cm, Depth: 0.20 cm; Etiology: Pressure Ulcer-Unstageable; Margin Detail: Attached Edges; Woundbed Assessment: Eschar; Drain Amount/Description: Small, Serous; Notes: Rx (Prescription): Cleanse with Betadine QD (Daily) and PRN (as needed); apply lodosorb to open areas at the edges; secure with ABD (Army Battle Dressing) and Kerlix QD and PRN. Surveyor was unable to locate the second part of the order for the treatment of R66's left heel pressure injury in R66's TAR (Treatment Administration Record). Surveyor noted that R66 was only receiving betadine to the left heel and missing the following part of the treatment order: Apply lodosorb to open areas at the edges; secure with ABD (Army Battle Dressing) and Kerlix QD and PRN. Surveyor noted that despite missing the second part of the treatment order, R66's left heel pressure injury was healing and improving since being admitted to the facility. R66's Skin Integrity plan of care dated as initiated on 7/8/19 documents under the Focus section, At moderate risk for skin integrity Score on Braden Assessment for Pressure Ulcers .Diabetes Mellitus, Weakness. Surveyor was unable to locate any offloading interventions for R66's heels in R66's Skin Integrity plan of care. On 7/7/21 at 10:07 a.m., Surveyor interviewed R66 regarding the pressure injuries to his heels. Surveyor asked R66 if facility staff offered to offload his heels to prevent further injury and promote healing. R66 informed Surveyor that facility staff offered to float his heels from time to time and that he did not mind having his heels offloaded. On 7/8/21 at 3:35 p.m., Surveyor observed R66 laying supine in bed with both heels resting directly on the mattress and not offloaded to prevent further injury and promote healing of R66's heel unstageable pressure injuries. On 7/12/21 at 8:04 a.m., Surveyor observed R66 laying supine in bed with both heels resting directly on the mattress and not offloaded to prevent further injury and promote healing of R66's heel unstageable pressure injuries. On 7/12/21 at 12:17 p.m., Surveyor informed Wound RN (Registered Nurse)-C of the above findings. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Surveyor asked Wound RN-C if R66 should have his heels offloaded to prevent further injury and promote healing of R66's pressure injuries. Wound RN-C informed Surveyor that R66 should have his heels offloaded to prevent further injury and promote healing of R66's pressure injuries. Surveyor asked Wound RN-C why R66 did not have offloading interventions for his heels in his plan of care. Wound RN-C informed Surveyor that R66 should have had offloading interventions for his heels in his plan of care , but that due to the change in the EHR (Electronic Health Record) systems the facility recently went through, R66's offloading heel interventions were not added to his new plan of care. Surveyor asked Wound RN-C why R66's wound treatment order dated 6/18/21 was not included in R66's current wound treatment orders. Wound RN-C reviewed the order and informed Surveyor that she would add the second part of the wound order to R66's current wound order treatment. On 7/13/21 at 11:54 a.m., Surveyor informed DON (Director of Nursing)-B of the above findings. No additional information was provided. 4.) R64 was readmitted to the facility on [DATE] with a diagnosis that included Hemiplegia and Hemiparesis, Diabetes Mellitus Type II and Left Wrist and Left Hand Contracture and Right Lower Leg Contracture. R64's Quarterly MDS (Minimum Data Set) dated 6/14/21 documents that R64 has short and long term memory problems. Section C1000 (Cognitive Skills for Daily Decision Making) documents that R64 has severely impaired cognitive skills for daily decision making. Due to R64's mental status at the time of the survey, Surveyor was unable to interview R64. Section G (Functional Status) documents that R64 requires extensive staff assistance and a two person physical assist for her bed mobility and transfer needs. Section G0400 (Functional Limitation in Range of Motion) documents that R64 has impairment to one side of her upper and lower extremities. Section M (Skin Condition) documents that R64 is at risk for the development of pressure injuries. R64's Pressure Ulcer/Injury CAA (Care Area Assessment) dated 4/7/21 documents under the Analysis of Findings section, Resident at risk for developing pressure ulcers as indicated by: Comorbidities. R64's Braden Scale for Predicting Pressure Sore/Injury assessment dated [DATE] documents a score of 13, indicating that R64 is at moderate risk for the development of pressure injuries. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R64's most recent Left Lateral Wound Summary assessment dated [DATE] documents, Status: Active; Clinical Stage: Stage 3; Tissue Types: Necrotic Hard, Firm, Adherent-100%; Infection Present: Unable to determine; Exudate: Moderate; Length: 0.70 (centimeters); Width: 1.00 cm ; Depth: 0.60 cm. Surveyor noted that R64's unstageable left lateral pressure injury was improving since. Surveyor noted a decrease in the size of the wound, weekly assessments with measurements and wound bed descriptions, physician notification and following of the wound by a wound physician. R64's Skin Integrity plan of care dated as initiated on 7/27/20 documents under the Focus section, At risk for impaired skin integrity: Score on the Braden Scale Assessment for Pressure Ulcers; History of Pressure Ulcers; Cognitive impairment, Contractures of BILATERAL LOWER EXTREMITIES. Under the Interventions section it documents, Date Initiated: 04/27/2021: Bilateral heel boots on at all times except for cares. On 7/8/21 at 3:37 p.m., Surveyor observed R64 laying supine in bed with both heels resting directly on the mattress and not wearing heel boots per her plan of care. On 7/12/21 at 8:05 a.m., Surveyor observed R64 laying supine in bed with both heels resting directly on the mattress and not wearing heel boots per her plan of care. On 7/12/21 at 11:48 a.m., Surveyor observed R64 laying supine in bed with both heels resting directly on the mattress and not wearing heel boots per her plan of care. On 7/12/21 at 1:12 p.m., Surveyor observed R64 laying supine in bed with both heels resting directly on the mattress and not wearing heel boots per her plan of care. On 7/12/21 at 3:23 p.m., Surveyor observed R64 laying supine in bed with both heels resting directly on the mattress and not wearing heel boots per her plan of care. On 7/12/21 at 12:17 p.m., Surveyor informed Wound RN (Registered Nurse)-C of the above findings. Surveyor asked Wound RN-C if R64 should have her heels offloaded to prevent further injury and promote healing of R64's pressure injury. Wound RN-C informed Surveyor that R64 should have his heels offloaded to prevent further injury and promote healing of R64's pressure injury. On 7/13/21 at 11:54 a.m., Surveyor informed DON (Director of Nursing)-B of the above findings. No additional information was provided. 43319 5.) R8 was admitted to facility on 3/5/21, and has diagnosis of encephalopathy, methicillin resistant staphylococcus aureus, sepsis, bacteremia, clostridium difficile, stage 4 pressure ulcer of sacral region, osteomyelitis, paranoid schizophrenia, bipolar disorder, Parkinson's and urinary, tract infection. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525547	A. Building B. Wing	07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glendale Care and Rehab Center LLC	6263 N Green Bay Ave Glendale, WI 53209

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	R8's Minimum Data Set (MDS) assessment, dated 6/10/21, indicated R8 has a Brief Interview for Mental Status (BIMS) score of 6, which indicates R8 is severely impaired for daily decision making skills. R8 is on a repositioning program, extensive assist of one with bed mobility, extensive assist of 2 with transfers, incontinent of bowels and catheter for urine. R8's Care Plan, dated 3/11/21, revised on 7/06/21, with a target date of 9/20/21, states: . R8's is at risk for skin integrity, score on [NAME] Assessment for pressure ulcers, incontinence, weakness, actual stage IV pressure ulcer to sacral region. Interventions: *positioning wedge to be utilized and place at lower back. *Reposition at frequent intervals and PRN (as needed). *Wedge cushion may be used for repositioning as needed. R8's Braden Skin Assessment score on 6/24/21 was 14, indicating R8's is at a moderate risk for pressure injury. On 7/07/21, at 09:11 AM, Surveyor observed R8 lying in bed on his back with head of the bed elevated about 30 degrees. R8's heels were resting on air mattress, one heel boot on the floor and blue wedge cushion for positioning, lying on the floor under his bed at the foot of his bed. On 07/07/21, at 10:21 AM, Surveyor observed R8 lying in bed on his back slouched down, head of the bed up about 30 degrees. R8's legs slightly bent and leaning to his left side with green pressure reducing boots on both feet resting on the bed. R8 was unable to straighten legs on his own. On 07/07/21, at 11:58 AM, Surveyor observed R8 in bed continues to lay on his back. R8 has one green pressure reducing heel boot on and one laying on the floor. On 07/08/21, at 07:52 AM, Surveyor observed R8 sleeping in bed lying on his back. R8 had pressure relieving boots on bilateral feet resting on the bed. On 07/08/21, at 10:45 AM, Surveyor observed R8 lying in bed on his back and slouched down. R8's head of the bed was raised to 45 degrees. R8 was removing his clothes and his blanket was on the floor with no fall mat in place. On 07/08/21, at 11:12 AM, Surveyor observed Certified Nursing Assistant (CNA)-F go into R8's room, covered him up and put fall mat in place. CNA-F returned a five minutes later to provide cares. On 7/08/21, at 11:17 AM, Surveyor spoke with CNA-F about how often R8 should be repositioned. CNA-F informed surveyor R8 should be repositioned every 2 hours. R8 currently has a stage 4 pressure injury to sacral region. The facility staff did not implement the interventions on R8's care plan for repositioning frequently or use the wedge cushion for positioning.