STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525604	A. Building B. Wing	06/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southpointe Care and Rehab Center LLC	4500 W Loomis Rd Greenfield, WI 53220

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41439 Based on observation, interview and record review the facility did not ensure residents were treated with dignity and respect for 1 (R407) of 18 sampled residents. *R407 was observed from the hallway with his legs spread open exposing a heavily saturated brief. [NAME] colored matter was observed coming out on the edges of the brief. The smell of urine and bowel matter was evident when the Surveyor entered his room. R407 was observed tapping at his brief with his hand multiple times appearing to try to draw attention to his need to be changed. R407 was assessed by facility staff to identify Spanish as his preferred language and need/want an interpreter to communicate with his physician and Health Care staff. Findings include: R407 was admitted to the facility on [DATE] and has diagnoses that include, but are not limited to, cerebral infarction, dysphagia following cerebral infarction, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, heart disease and chronic kidney disease. R407's Minimum Data Set (MDS) Quarterly assessment dated [DATE] Section A: Identification Information - Language identifies R407 as needing and wanting an interpreter to communicate with a doctor or health care staff and his preferred language is Spanish. Section C: Cognitive Patterns documents a R407's Brief Interview for Mental Status (BIMS) was scored at 6 which indicated severe cognitive impairment; Patient Health Questionnaire (PHQ-9) score of 9, indicating mild depressive symptoms; R407 is dependent on 2 + staff for transfers, requires extensive assist of 2 + staff for bed mobility, dressing and toilet use; dependent on 1 person for eating and personal hygiene; has limited range of motion to upper and lower extremities on one side; is occasionally incontinent of bladder and frequently incontinent of bowel, the facility has not trialed a toileting program and is not currently using a toileting program. On 6/27/22 at 12:21 PM, Surveyor reviewed R407's care plan which documents: R407 has an Activities of Daily Living (ADLs) self-care performance deficit due to CVA (cerebrovascular accident). Date initiated, 3/10/21 and revised on 6/3/22, interventions include: Resident is totally dependent on (1) staff for toilet use; Bowel incontinence due to CVA with hemiparesis; (continued on next page)

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

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Check resident frequently and assist with toileting as needed, Date initiated 3/10/21 and revised on 6/20/22 Care plan also documents R407 has a communication problem due to language barrier, speaks Spanish with very little English, date initiated 3/10/21. Interventions include: Observe/document for physical/nonverbal indicators of discomfort or distress and follow up as needed. On 6/27/22, at 11:58 AM, Surveyor observed R407 lying in bed on his back. The head of the bed (HOB) was elevated. Resident was wearing a hospital gown that was draped open exposing his bare chest and legs. R407 was wearing a brief that appeared to be saturated as it was bulging between his legs. On 6/27/22, at 2:00 PM, Surveyor observed R407 lying in bed on his back. R407 was wearing a hospital gown that was draped open and exposing his bare chest and legs. R407's legs were spread open exposing the heavily saturated brief. [NAME] colored matter was observed coming out on the edges of the brief. Surveyor noted the smell of urine and bowel matter in the room. R407 was observed tapping at his brief with his hand multiple times. On 6/27/22, at 3:21 PM, Surveyor observed R407 lying in bed on his back. R407 was wearing only a brief. [NAME] colored matter was observed coming out on the edges of the brief. The bedsheet under R407 was stained with yellow and brown matter. Surveyor noted the smell of urine and bowel matter in the room. On 6/28/22, at 10:00 AM, Surveyor interviewed Licensed Practical Nurse-C (LPN-C) and asked how staff communicates with R407. LPN-C stated most of the time he speaks in Spanish. He does say some words in English, like he will ask for a urinal. LPN-C stated we ask him questions if we don't understand him or find a staff person who speaks Spanish. R407 was not treated with dignity as he was not fully clothed or covered and visible from the hallway wearing a soiled, bulging brief with brown colored matter observed coming out the edges of the brief. R407's bedsheet was stained with yellow and brown matter and the smell of urine was noted in the room. R407 was aware of his incontinence and was attempting to communicate this to others by tapping on his brief multiple times.

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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** 41439 Based on record review and interviews, the facility did not immediately notify the resident representative of R66's change in condition including wound care and lethargy which may have required the facility to alter treatment or commence a new form of treatment for 1 (R66) of 5 sampled residents. R66's resident representative was not notified with changes in wound treatments/plan, change in mental state (lethargy), significant change in functioning, and psych referral for sadness, anger and depression. Findings include: The facility policy, Changes in Resident Condition, dated April 2005, revised February 2017, indicated the nursing staff, the resident, the attending physician, and the resident's legal representative are notified when changes in the resident's condition occur. R66 was admitted to the facility on [DATE] and recently hospitalized from 4/19/22 to 5/4/22 and 5/5/22 to 5/19/22. R66's diagnoses included Stroke with Left Hemiplegia (non-dominant side), Diabetes, PVD (Peripheral Vascular Disease) Cardiomyopathy, Heart Failure, CAD (Coronary Artery Disease) Osteoarthritis, and Depression. R66's 5/27/22 Significant Change MDS indicated R66 was cognitively intact requiring extensive assistance with 1-2 staff for bed mobility, and functional limitation with impairment on one side for upper and lower extremity. Surveyor reviewed R66's medical records and available hospital records. R66 was noted by the podiatrist on 3/23/22 to have 3 wounds with redness and swelling of right foot with recommendation for hospitalization for evaluation and treatment. R66 refused and was treated with antibiotics by NP (Nurse Practitioner) with plan for the Physician and Wound Nurse to see him as soon as possible. On 4/12/22, R66's diabetic foot ulcer to the right hallux/right medial foot was noted to be a full thickness wound with 100% brown adhesive slough with drainage and was debrided by the Wound NP. *Wound NP did not update R66's significant other (spouse) of the debridement and treatment. WCRN-F (Wound Care RN) documented his wound information on 4/12/22 in the Skin non-pressure weekly condition record and indicated notification of self (R66). *WCRN-F did not update R66's significant other (spouse) of the wound assessment and plan. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/19/22, Wound NP documented in R66's Wound Assessment that Patient appears lethargic, lying in bed. Per nursing staff, he has been not acting himself for the last couple of days, especially requiring more assistance with transfers and increasing lethargy. Today, he arouses to touch. He reports he feels out of it today. In the past, he has declined ER transport but today is agreeable. No fevers/chills per nursing staff, he is afebrile at 97.5 F. Blood sugars reviewed and in acceptable range, continue glycemic control. *The facility did not update R66's significant other (spouse) of his increased lethargy or not acting himself for the last couple days. R66 was transferred to the hospital on 4/19/22 and returned to the facility on [DATE] with an order for wound vac to right foot, which was placed at the facility on 5/5/22 by WCRN-F. On 5/5/22, R66's IDT (Interdisciplinary Team Risk Meeting) progress note indicated resident is his own RP (Responsible Party) and agreeable to the treatment plan. *The facility IDT did not update R66's significant other (spouse) of the treatment plan despite recent lethargy, not acting himself and infection. R66's 5/5/22 progress note indicated spouse called several times this shift trying to get through to the nurses desk. Spouse stated concern as R66 stated having 3 new wounds and wants him sent back to the hospital. R66 was transferred to the hospital on 5/5/22 and returned to the facility on [DATE] with Right BKA (Below Knee Amputation). On 5/25/22, R66's SW- K (Social Worker) progress note indicated meeting with R66 who presented as sad with flat affect and appeared depressed and angry regarding BKA. SW-K offered psych services and referral accepted with skepticism. *SW-K did not update R66's significant other (spouse) of the psych services and referral. On 5/26/22, R66's IDT progress note indicated R66 had a significant change discussing nursing and therapy documentation. *The facility IDT did not update R66's significant other (spouse) of the significant change in performance and change to plan. On 5/29/22, R66's nursing progress note indicated R66 was lethargic during shift with poor appetite. On 6/29/22, at 3:00 PM, the Survey Team shared concerns regarding R66's lack of notification to resident representative with updates on changes/plan of care and requested change in condition/notification policy. No further information was provided.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20483 Based on interview & policy review, the Facility did not ensure 1 (R62) of 1 allegations of misappropriation of resident property were immediately reported to the State Survey Agency. Findings include: The Abuse & Neglect Prohibition Policy & Procedure with a revision date of July 2018 under Procedures for Reporting and Response documents 1. STATE REPORTING OBLIGATIONS: The facility will report all allegations and substantiated occurrences of abuse, neglect, exploitation, mistreatment including injuries of unknown origin, and misappropriation of property to the administrator, State Survey Agency, and law enforcement officials and adult protective services (where state law provides for jurisdiction in long-term care facilities) in accordance with Federal and State law through established procedures. The Social Service note dated 5/27/22 documents SW (Social Worker) spoke with resident's granddaughter [name] who stated that resident will be going to a hospice within a hospital and will not be returning to facility. She will be in facility on Saturday, 5/28/22 to retrieve all of resident's personal belongings . On 6/28/22 at 3:04 p.m. Surveyor spoke with SW (Social Worker)-K on the telephone and inquired if anyone reported missing clothing for R62 to her. SW-K replied she actually did. Surveyor inquired who she was. SW-K explained R62's granddaughter reported several items of clothing were missing when she was packing up R62's belongings. SW-K informed Surveyor she did write up a concern regarding the missing clothing. Surveyor informed SW-K Surveyor had reviewed the Facility's grievance log starting 4/7/22 and did not note this on the Facility's grievance log. SW-K informed Surveyor she's not sure why this was not listed on the log. Surveyor asked SW-K if she has the concern form. SW-K informed Surveyor she believes Administrator-A has it. Surveyor asked SW-K to provide the concern form to Surveyor. Surveyor also asked SW-K if R62's missing items were reported to the State agency. SW-K informed Surveyor she doesn't know and can ask Administrator-A. On 6/29/22 at 8:41 a.m. Surveyor received an email from SW-K which documented Attached you will find the concern form for [R62]. I also spoke with the Administrator, and she stated this was not reported. Surveyor reviewed the concern form dated 5/29/22. Under description of concern (summary) documents Missing: * neon orange shirt * blue t shirt w/ (with) wrestler on it ultimate [NAME] * black t shirt with 1977 car * red coke shirt * gray jacket zip up (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	* white t shirt w/red writing says 'Istanbul'. On 6/29/22 at 3:03 p.m. during the end of the day meeting with Administrator-A and DON (Director of Nursing)-B Surveyor inquired why R62's missing clothing was not reported to the State Survey Agency. Administrator-A replied I don't know, wasn't here. Administrator-A explained she looked in a drawer which contained other self reports but didn't see one for R62. Surveyor informed Administrator-A if she locates a self report for R62's missing clothing to inform Surveyor. No additional information was provided to Surveyor.

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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** 41439 Based on observation, interview and record review the facility did not ensure residents received timely and thorough assistance with Activities of Daily Living (ADLs) and assistance with toileting for 1 (R407) of 7 sampled residents. *R407 was observed multiple times on one day to have not received toileting care in a timely manner. Findings Include: The facility policy, entitled Standards of Care for C.N.A. Practice, revision date of February 2017, states We believe that each resident has the right to be treated with dignity and respect and that privacy must be maintained during procedures. Guidelines: 1. C.N.A. required skills include: a. Following standards and procedures for the provision of services and care for residents; b. Assisting the resident in activities of daily living such as eating, drinking, turning and positioning, transfer and ambulation including walking, bathing, oral care, grooming, dressing, toileting, communication and socialization; c. Accurately and timely documenting care provided as required by facility policy; f. Making routine rounds to check each assigned resident's condition and ensure their needs are met; R407 was admitted to the facility on [DATE] and has diagnoses that include, but are not limited to, cerebral infarction, dysphagia following cerebral infarction, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, heart disease and chronic kidney disease. R407's Minimum Data Set (MDS) Quarterly assessment dated [DATE] Section A: Identification Information - Language identifies R407 as needing and wanting an interpreter to communicate with a doctor or health care staff and his preferred language is Spanish. Section C: Cognitive Patterns documents a R407's Brief Interview for Mental Status (BIMS) was scored at 6 which indicated severe cognitive impairment. Section G: Functional Status, Section I: Toileting use, documents R407 requires total dependence and two+ person's physical assist. Section GG: Functional Abilities and Goals Section C. Toileting, documents R407 as dependent. (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/27/22 at 12:21 Surveyor reviewed R407's care plan. It states that R407 has an Activities of Daily Living (ADLs) self-care performance deficit due to CVA (cerebrovascular accident). Date initiated 3/10/21 and revised on 6/3/22 intervention states that R407 is totally dependent on (1) staff for toilet use. Bowel incontinence due to CVA with hemiparesis is in the care plan. Date initiated 3/10/21 and revised on 6/20/22 intervention states check resident frequently and assist with toileting as needed. Care plan also documents R407 has a communication problem due to language barrier, speaks Spanish with very little English. Date initiated 3/10/21 with interventions to observe/document for physical/nonverbal indicators of discomfort or distress and follow up as needed. On 6/27/22 at 11:58 AM Surveyor observed R407 laying in bed on his back. The head of the bed (HOB) was elevated. Resident was wearing a hospital gown that was draped open exposing his bare chest and legs. R407 was wearing a brief that appeared to be saturated as it was budging between his legs. On 6/27/22 at 2:00 PM Surveyor observed R407 laying in bed on his back. R407 was wearing a hospital gown that was draped open and exposing his bare chest and legs. R407's legs were spread open exposing the heavily saturated brief. [NAME] color matter was observed coming out on the edges of the brief. Surveyor noted the smell of urine and bowel matter in the room. R407 was observed tapping at his brief with his hand multiple times. On 6/27/22 at 3:21 PM Surveyor observed R407 laying in bed on his back. R407 was wearing only a brief. [NAME] color matter was observed coming out on the edges of the brief. The bedsheet under R407 was stained with yellow and brown matter. Surveyor noted the smell of urine in the room. On 6/27/22 at 3:40 PM Surveyor interviewed Certified Nursing Assistant-D (CNA-D) and asked how often R407 should be checked for toileting needs. Stated every 2 hours staff should be checking on him as he is incontinent a lot. On 6/27/22 at 3:42 PM Surveyor interviewed CNA-E and asked how often R407 should be checked for toileting needs. Stated that she worked first shift today and checked on him around noon and will be going back in now to check him. On 6/28/22 at 10:00 AM Surveyor interviewed Licensed Practical Nurse-C (LPN-C) and asked how staff communicates with R407. LPN-C sated that most of the time he speaks in Spanish. He does say some words in English, like he will ask for a urinal. We ask him questions if we don't understand him of find a staff person who speaks Spanish. On 6/28/22 at 1:18 PM Surveyor interviewed Director of Nursing-B (DON) and asked what the expectation for staff is monitoring toileting for a dependent resident in briefs. DON-B stated staff should be checking on residents every 2 hours. She stated that most of our residents can tell us when they need to go and most of our staff know their residents well and can anticipate their needs. On 6/28/22 at 3:00 PM at the daily end of day meeting Surveyor expressed the above concerns with Nursing Home Administrator-A And DON-B. No additional information was provided.

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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** 20483 Based on observation, interview, and record review, the Facility did not ensure Residents with pressure injuries receive appropriate care, treatment, & preventative measures to promote healing for 2 (R406 & R400) of 4 Residents with pressure injuries reviewed. * R406 was readmitted to the facility on [DATE] with a Stage 2 pressure injury to the left buttocks. On 5/17/22 R406 developed a Stage 3 pressure injury to the coccyx. There were no revision to R406's skin integrity care plan until 6/3/22. On 5/24/22 R406's left buttocks pressure injury had declined to unstageable. There were no revisions to R406's skin integrity care plan until 6/3/22. On 6/28/22 a Surveyor observed medihoney being applied to the coccyx & left buttocks wound bed when the physicians order was for collagen. There were multiple observations of R406's heels not being offloaded and not wearing the pressure relieving boots. There is no evidence daily foot inspections were being conducted according to the plan of care after R406 returned from the hospital on 5/9/22. On 6/28/22 R406 was identified as having a DTI (deep tissue injury) on the right heel. * R400 acquired a coccyx pressure injury on 6/16/22. R400 did not have a low air loss mattress. Surveyor observed R400 without heel boots and did not observed consistent repositioning, Treatment orders were not updated on 6/23/22 and on 6/29/22 a second coccyx pressure injury developed. Findings include: 1.) R406 was originally admitted to the facility on [DATE]. Diagnoses include Parkinson's Disease, Diabetes Mellitus, Vascular Disease with behavioral disturbances, protein-calorie malnutrition, and adult failure to thrive. On 5/23/22 R406 was placed on hospice. The diabetes mellitus care plan initiated & revised on 2/13/22 documents an intervention of Inspect feet daily for open areas, sores, pressure areas, blisters, edema or redness. Initiated 2/13/22. The potential for pressure ulcer development care plan initiated 2/15/22 & revised 6/28/22 has the following interventions: * Administer treatments as ordered and observe for effectiveness. Initiated 2/15/22. * Assess/record/observe wound healing: Measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report improvements and declines to the MD (medical doctor). Initiated 2/15/22 & revised 6/3/22. * Assist [R406] to float heels while in bed. Initiated 6/25/22. * Assist [R406] to reposition and/or turn at frequent intervals at least Q2-3H (every two to three hours), to provide pressure relief. Initiated & revised 2/15/22. * Complete a full body check weekly and document. Initiated 2/15/22. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	* Follow facility policies/protocols for the prevention/treatment of skin breakdown. Initiated 2/15/22. * IDT (interdisciplinary team) referrals as indicated, i.e. RD (registered dietitian), PT (physical therapy), OT (occupational therapy) or other. Initiated 2/15/22 & revised 6/3/22. * Inform the resident/family/caregivers of any new area of skin breakdown. Initiated 2/15/22. * Observe nutritional status. Serve diet as ordered, observe intake and record. Initiated 2/15/22. * Reposition in chair frequently for comfort and pressure reduction. Provide resident/family education as needed. Initiated 2/15/22 & revised 6/3/22. * The resident needs assistance to turn/reposition at least every 2-3 hours, more often as needed or requested. Initiated 2/15/22 & revised 6/3/22. * The resident requires supplemental protein, amino acids, vitamins, minerals as ordered to promote wound healing. Initiated 2/15/22. * The resident requires a pressure relieving/reducing device on (bed/chair). Initiated 2/15/22 & revised 6/3/22. * Treat pain as per orders prior to treatment/turning etc to ensure the resident's comfort. Initiated 2/15/22. * Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate. Initiated 2/15/22. On 5/4/22 R406 was admitted to the hospital with diagnoses of sepsis & UTI (urinary tract infection). R406 returned to the facility on [DATE]. The admission data collection dated 5/9/22 for the question Is residents skin intact? no is answered. For the question, Does the resident have pressure injury? yes is answered. Site is 53) Sacrum. There are no measurements or stage on this admission data collection. Left Buttocks The weekly pressure ulcer record dated 5/10/22 for date of onset documents 5/9/2022. Site is documented as 32) Left Buttocks, Type Pressure, Length 2.0, Width 0.5, Depth 0.1 and Stage II (2). Description of site documents 100% smooth pink wound bed, no drainage, edges attached, surrounding skin pink blanchable, no sign of infection, no c/o (complaint of) pain. Treatment is calazime paste. Under specialty interventions for bed type documents air mattress and under other interventions documents pressure relieving boots. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The weekly pressure ulcer record dated 5/17/22 for date of onset documents 5/9/2022. Site is documented as 32) Left Buttocks, Type Pressure, Length 1.1, Width 1.4, Depth 0.1 and Stage II (2). Description of site documents 100% smooth pink wound bed, small sero-sang. drainage, edges attached, surrounding skin pink blanchable, no sign of infection no c/o pain. Under describe resident's response to treatment no change is marked. Under notes documents stable. Treatment was changed to medihoney/border foam. Under specialty interventions for bed type documents air mattress and under other interventions documents pressure relieving boots. The weekly pressure ulcer record dated 5/24/22 for date of onset documents 5/9/2022. Site is documented as 32) Left Buttocks, Type Pressure, Length 1.6, Width 1.9, Depth 0.1 and Stage Unstageable. Description of site documents 80% slough 10% purple 10% granulation wound bed. Under describe resident's response to treatment deteriorated is marked. Under notes documents increase in surface area. There was no change in treatment. Under specialty interventions for bed type documents air mattress and under other interventions documents pressure relieving boots. Surveyor noted there was no revision in R406's skin integrity care plan until 6/3/22. Surveyor notes R406's care plan did not reference an air mattress or pressure relieving boots despite reference to being specialized interventions in the weekly pressure ulcer record. The weekly pressure ulcer record dated 5/31/22 for date of onset documents 5/9/2022. Site is documented as 32) Left Buttocks, Type Pressure, Length 1.6, Width 1.6, Depth utd (unable to determine) and Stage Unstageable. Description of site documents 100% slough wound bed, moderae sic (moderate) sero-sang. drainage, edges attached, surrounding skin pink blanchable, no sign of infection, no c/o pain. Under describe resident's response to treatment improved is marked. Under notes documents decrease in surface area. There was no change in treatment. Under specialty interventions for bed type documents air mattress and under other interventions documents pressure relieving boots. The weekly pressure ulcer record dated 6/7/22 for date of onset documents 5/9/2022. Site is documented as 32) Left Buttocks, Type Pressure, Length 1.1, Width 1.4, Depth utd and Stage Unstageable. Description of site documents 100% slough wound bed, moderate serous drainage, edges attached, surrounding skin dark discolored, no sign of infection, no c/o pain. Under describe resident's response to treatment improved is marked. Under notes documents decrease in surface area. There was no change in treatment. Under specialty interventions for bed type documents air mattress and under other interventions documents pressure relieving boots. The weekly pressure ulcer record dated 6/14/22 for date of onset documents 5/9/2022. Site is documented as 32) Left Buttocks, Type Pressure, Length 1.3, Width 1.0, Depth utd and Stage Unstageable. Description of site documents 100% slough wound bed, moderate serous drainage, edges attached, surrounding skin dark discolored, no sign of infection, no c/o pain. Under describe resident's response to treatment improved is marked. Under notes documents decrease in surface area. There was no change in treatment. Under specialty interventions for bed type documents air mattress and under other interventions documents pressure relieving boots. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525604	A. Building B. Wing	06/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southpointe Care and Rehab Center LLC	4500 W Loomis Rd Greenfield, WI 53220

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	The weekly pressure ulcer record dated 6/16/22 for date of onset documents 5/9/2022. Site is documented as 32) Left Buttocks, Type Pressure, Length 1.3, Width 1.0, Depth utd and Stage N/A (non applicable). Description of site documents 100% slough wound bed, moderate serous drainage, edges attached, surrounding skin dark discolored, no sign of infection, no c/o pain. Under describe resident's response to treatment no change is marked. Under notes documents stable. There was no change in treatment. Under specialty interventions for bed type documents air mattress and under other interventions documents pressure relieving boots. The weekly pressure ulcer record dated 6/23/22 for date of onset documents 5/9/2022. Site is documented as 32) Left Buttocks, Type Pressure, Length 1.5, Width 1.5, Depth 0.1 and Stage III (3). Description of site documents 100% granulation wound bed, moderate sero-sang. drainage, edges attached, surrounding skin pink blanchable, no sign of infection, no c/o pain. Under describe resident's response to treatment deteriorated is marked. Under notes documents increase in surface area. Treatment was changed to collagen/border foam. Under specialty interventions for bed type documents air mattress and under other interventions documents pressure relieving boots. Coccyx The weekly pressure ulcer record dated 5/17/22 for date of onset documents 5/17/2022. Site is documented as 23) Coccyx, Type Pressure, Length 1.0, Width 0.5, Depth 0.2 and Stage III (3). Description of site documents 100% granulation wound bed, scant sero-sang. drainage, edges attached, surrounding skin pink blanchable, no sign of infection, no c/o pain. Treatment is medihoney/border foam. Surveyor noted there was no revision in R406's skin integrity care plan until 6/3/22. The weekly pressure ulcer record dated 5/24/22 for date of onset documents 5/17/2022. Site is documented as 23) Coccyx, Type Pressure, Length 1.5, Width 1.2, Depth 0.1 and Stage III (3). Description of site documents 25% slough, 75% granulation wound bed, moderate sero-sang. drainage, edges attached, surrounding skin pink blanchable, no sign of infection, no c/o pain. Under describe resident's response to treatment deteriorated is marked. Under notes documents increase in surface area. There was no change in treatment. Under specialty interventions for bed type documents air mattress and under other interventions documents pressure relieving boots. Surveyor noted there was no revision in R406's skin integrity care plan until 6/3/22. The weekly pressure ulcer record dated 5/31/22 for date of onset documents 5/17/2022. Site is documented as 23) Coccyx, Type Pressure, Length 0.9, Width 0.7, Depth 0.1 and Stage III (3). Description of site documents 100% granulation wound bed, moderate sero-sang. drainage, edges attached, surrounding skin pink blanchable, no sign of infection, no c/o pain. Under describe resident's response to treatment improved is marked. Under notes documents decrease in surface area. There was no change in treatment. Under specialty interventions for bed type documents air mattress and under other interventions documents pressure relieving boots. (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	The weekly pressure ulcer record dated 6/7/22 for date of onset documents 5/17/2022. Site is documented as 23) Coccyx, Type Pressure, Length 0.9, Width 0.7, Depth utd and Stage Unstageable. Description of site documents 100% slough wound bed, moderate serous drainage, edges attached, surrounding skin dark discolored, no sign of infection, no c/o pain. Under describe resident's response to treatment no change is marked. Under notes documents stable. There was no change in treatment. Under specialty interventions for bed type documents air mattress and under other interventions documents pressure relieving boots. Surveyor noted R406's wound bed declined to 100% slough and the care plan was not revised until 6/25/22 with an intervention of float heels while in bed implemented. The weekly pressure ulcer record dated 6/14/22 for date of onset documents 5/17/2022. Site is documented as 23) Coccyx, Type Pressure, Length 0.9, Width 0.7, Depth utd and Stage Unstageable. Description of site documents 100% slough wound bed, moderate serous drainage, edges attached, surrounding skin dark discolored, no sign of infection, no c/o pain. Under describe resident's response to treatment improved is marked. Under notes documents decrease in surface area. There was no change in treatment. Under specialty interventions for bed type documents air mattress and under other interventions documents pressure relieving boots. Surveyor noted this pressure injury did not improve as the measurements continue to be the same and the wound bed is still 100% slough. The weekly pressure ulcer record dated 6/16/22 for date of onset documents 5/17/2022. Site is documented as 23) Coccyx, Type Pressure, Length 0.9, Width 0.7, Depth utd and Stage Unstageable. Description of site documents 100% slough wound bed, moderate sero-sang drainage, edges attached, surrounding skin dark discolored, no sign of infection, no c/o pain. Under describe resident's response to treatment no change is marked. Under notes documents stable. There was no change in treatment. Under specialty interventions for bed type documents air mattress and under other interventions documents pressure relieving boots. The weekly pressure ulcer record dated 6/23/22 for date of onset documents 5/17/2022. Site is documented as 23) Coccyx, Type Pressure, Length 0.7, Width 0.4, Depth 0.1 and Stage III (3). Description of site documents 100% granulation wound bed, moderate sero-sang drainage, edges attached, surrounding skin pink blanchable, no sign of infection, no c/o pain. Under describe resident's response to treatment improved is marked. Under notes documents decrease in surface area. Treatment was changed to collagen/border foam. Under specialty interventions for bed type documents air mattress and under other interventions documents pressure relieving boots. The Braden assessment dated [DATE] has a score of 14 which indicates moderate risk. The physician orders dated 5/10/22 documents Pressure relieving boots on at all times. May remove for cares and therapy. Check for placement q (every) shift. Surveyor noted weekly head to toe skin checks dated 5/10/22, 6/14/22, 6/21/22, & 6/28/22. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The nurses note dated 5/12/22 documents IDT weekly wound note [R406] has an admitted with wound to the left buttock with his last re admission from the hospital. Treatment is in place. He has nutritional supplements in place. MD and brothers are aware and agreeable with the treatment plan. Care plan is updated. He will continue to be monitored per facility protocol. The quarterly MDS (minimum data set) with an assessment reference date of 5/14/22 documents a BIMS (brief interview mental status) score of 6 which indicates severe impairment. R406 is coded as not having any behaviors including refusal of care. R406 requires extensive assistance with bed mobility, does not ambulate, requires supervision with set up help only for eating, is dependent with one person physical assist for toilet use, is checked for an indwelling catheter and is always incontinent of bowel. R406 is at risk for pressure injury development and is coded as having one Stage 2 pressure injury. The nurses note dated 5/16/22 includes documentation of .There sic (there) are 2 skin tears on but (sic) cheeks. No bleeding present. Cream and paste was applied. Continue to monitor the resident. This note was written by LPN (Licensed Practical Nurse)-M. The nurses note dated 5/20/22 documents IDT weekly wound note - [R406] an an admitted wound to the left buttock and a newly acquired wound to the coccyx. The wound to the left buttock is stable. Treatment recently changed. Treatment in place for the wound to the coccyx. He has nutritional supplements in place. He is declining as a whole. Family has been considering hospice R/T (related to) his decline. Care plan is up to date. MD and family agreeable to the current POC (plan of care). He will be monitored per facility protocol. The significant change MDS with an assessment reference date of 5/25/22 documents a BIMS score of 5 which indicates severe impairment. R406 is not coded as having any behavior including refusal of cares. R406 requires extensive assistance with two plus person physical assist for bed mobility, does not ambulate, requires extensive assistance with one person physical assist for eating, and dependent with one person physical assist for toilet use. R406 is checked for an indwelling catheter and is always incontinent of bowel. R406 is at risk for pressure injury development and is coded as having one Stage 3 and one Unstageable - slough &/or eschar pressure injury. The Pressure injury CAA (care area assessment) dated 5/26/22 under analysis of care for nature of the problem/condition documents Resident is a LTC (long term care) resident who was recently readmitted from [name of hospital] secondary to septic shock, UTI, dehydration and severe protein-calorie malnutrition. Pt (patient) has had multiple hospitalization s in the recent past and has had a decline since re-entry. He has now signed onto hospice for end of life cares. Resident is rarely getting out of bed at this time. During the look back period he has a catheter in place for urination and is always incontinent of bowel. No recent falls noted. He has two pressure injuries, a stage three pressure injury to the coccyx and an unstageable pressure injury to his L (left) buttocks. Treatments in place and a protein supplement is ordered. He takes psychotropic medications Venlafaxone, Bupropion and Remeron which he takes as ordered. He reports no pain in the past 5 days. The nurses note dated 5/26/22 documents IDT weekly wound note - [R406] has acquired wound to the coccyx and a left buttock wound that he was admitted with. Treatments will remain the same. He is now on hospice R/T his adult failure to thrive. He has nutritional supplements in place. Care plan has been updated. MD and family are aware and agreeable to the current POC. He will continue to be monitored per facility. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The nurses note dated 6/10/22 documents [R406] has an acquired wound to the coccyx and admitted wound to the left buttock. The wound to the left buttock has improved and wound to the coccyx in sic (is) stable. He remains on hospice care. Nutritional supplements remain in place. Care plan is updated. MD and family aware and agreeable to the current POC. He will continue to be monitored per facility protocol. The nurses note dated 6/16/22 documents IDT weekly wound note - [R406] has an acquired wound to the coccyx and admitted with wound to the left buttock. The wounds have both improved. Treatment will remain the same. Nutritional supplements are currently in place. MD and brother are aware and agreeable to the current POC. Care plan in place and up to date. He continued to be followed per facility protocol. The physician orders dated 6/23/22 include: 1. Cleanse (L) buttocks with normal saline f/b (followed by) skin prep to peri wound f/b collagen to wound bed, f/b border foam three times a week & PRN (as needed). Notify MD of S/S (signs/symptoms) of infection. 2. Cleanse coccyx wound with normal saline f/b skin prep to peri wound f/b collagen to wound bed, f/b border foam three times a week & PRN. Notify MD of S/S of infection. The nurses note dated 6/24/22 documents IDT weekly wound note - [R406] has an acquired wound to the coccyx and admitted with wound to the left buttock. Both wounds have improved. Both treatments were changed this week. Nutritional supplements are currently in place. MD and brother are aware and agreeable to the current POC. Care plan in place and up to date. He continue to be followed per facility protocol. On 6/27/22 at 12:02 p.m. Surveyor observed R406 in bed on his back with the head of the bed elevated on a proactive air mattress. R406 is wearing beige gripper socks and R406's heels are resting directly on the mattress. R406 is not wearing pressure relieving boots. On 6/27/22 at 1:05 p.m. Surveyor observed R406 in bed on his back with the head of the bed elevated on a proactive air mattress. R406 is wearing beige gripper socks and R406's heels are resting directly on the mattress & the balls of R406's feet are pressing against the foot board. R406 is not wearing pressure relieving boots. On 6/27/22 at 2:33 p.m. Surveyor observed R406 in bed on his back with a pillow case around R406's head and the head of the bed elevated on a proactive air mattress. R406 is wearing beige gripper socks and R406's heels are resting directly on the mattress & the balls of R406's feet are pressing against the foot board. R406 is not wearing pressure relieving boots. On 6/27/22 at 3:56 p.m. Surveyor observed R406 in bed on his back with the head of the bed elevated on a proactive air mattress. R406 is wearing beige gripper socks and R406's heels are resting directly on the mattress. R406 is not wearing pressure relieving boots. On 6/28/22 at 8:19 a.m. a Surveyor observed R406 in bed on his back wearing beige gripper socks. R406's heels were resting directly on the mattress and R406 was not wearing pressure relieving boots. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 6/28/22 at 9:50 a.m. a Surveyor observed R406 sitting in a Broda chair wearing bilateral pressure relieving boots. On 6/28/22 at 11:54 a.m. a Surveyor observed R406's left buttock and coccyx pressure injury treatment with Wound Care RN-F and LPN Unit Manager-L. Surveyor observed R406 is in bed on his back with his heels resting directly on the mattress. Surveyor observed Wound Care RN-F cleansed the left buttocks & coccyx with normal saline, applied medihoney to the wound beds, and covered each pressure injury with border foam dressing. Surveyor noted the physician orders dated 6/23/22 documents collagen is to be applied to the wound bed not medihoney. Surveyor asked Wound Care RN-F & LPN Unit Manager-L to look at R406's heels. R406's left heel is red and soft. LPN Unit Manager-L indicated R406 needs boots. The right heel has a DTI (deep tissue injury) which is a closed purple like blister. Wound Care RN-F indicated this is a brand new DTI and will measure. Wound Care RN-F applied skin prep to the right heel and then applied a border foam dressing on. R406 asked LPN Unit Manager-L for new socks as he has had these socks on for three days. The nurses note dated 6/28/22 documents Inadvertently applied medihoney to wound instead of collagen. Wound NP (nurse practitioner) called and also updated. Writer did explain to NP that slough was still slightly present in wounds. NP conveyed to writer to change orders to medihoney. NP also updated on new wound to R (right) heel. Tx (treatment) order confirmed. The SBAR (situation, background, assessment (RN)/Appearance (LPN), Response, Recommendations) note dated 6/28/22 documents RN Assessment/LPN Appearance of resident - What I think is going on with the resident is: Wound care reports a DTI (deep tissue injury) to R heel, noted during wound care, for coccyx. Area is 2.2 x 2.0 x utd (unable to determine). 100% deep purple, wound bed w/ (with) blister. NO drainage at this time, edges intact. Surrounding skin pink and blanchable. On 6/29/22 at 1:32 p.m. Surveyor spoke with LPN-M on the telephone regarding the nurses note she wrote on 5/16/22 which documented R406 had two skin tears on the buttocks. Surveyor asked LPN-M if she notified a RN regarding these skin tears. LPN-M informed Surveyor she didn't as when she was giving report the nurse told her the wound nurse knew about the skin tears and he can treat it. LPN-M explained to Surveyor she works the night shift. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 6/30/22 at 8:10 a.m. Surveyor spoke with Wound Care RN-F on the telephone regarding R406's pressure injuries. Surveyor asked Wound Care RN-F how R406 developed the coccyx pressure injury. Wound Care RN-F replied I don't know. I just write the order. Surveyor inquired who revises skin integrity care plans. Wound Care RN-F informed Surveyor he put the care plan in and changes or adds to the care plan. Surveyor informed Wound Care RN-F R406 was identified as having a coccyx pressure injury on 5/17/22 and the care plan was not revised until 6/3/22. Wound Care RN-F informed Surveyor he may have added interventions late. Surveyor asked why R406's coccyx pressure injury wasn't identified until it was a Stage 3. Wound Care RN-F replied that's a good question and explained staff are suppose to do skin checks with showers. Wound Care RN-F informed Surveyor staff calls him when they see something and may have been small. Wound Care RN-F informed Surveyor he didn't think it was real big and could have looked like white scar tissue and opened. Wound Care RN-F informed Surveyor he reminds staff to turn R406. Surveyor informed Wound Care RN-F of the observations on 6/27/22 of R406 on his back. Wound Care RN-F replied there you go. and informed Surveyor he's seen pillows behind R406's back. Surveyor informed Wound Care RN-F of the observations of R406's heels resting directly on the mattress, not wearing pressure relieving boots, and developed a DTI. Wound Care RN-F informed Surveyor he doesn't have an answer for that and doesn't check Residents every day. Wound Care RN-F explained he would see Residents on Tuesday for wound rounds but now wound rounds are on Thursdays. Wound Care RN-F informed Surveyor he knows R406 has boots but doesn't check to see if he is wearing them. On 6/30/22 at 8:55 a.m. Surveyor spoke with DON (Director of Nursing)-B on the telephone regarding R406. Surveyor informed DON-B R406's Diabetes Mellitus care plan has an intervention for daily inspection of feet and inquired where Surveyor would be able to locate this is being completed. DON-B informed Surveyor this would be on the MAR (medication administration record). Surveyor informed DON-B Surveyor reviewed the MAR & TAR (treatment administration record) starting after R406 returned to the facility on [DATE] and wasn't able to locate this. DON-B informed Surveyor it looks like it was on the MAR and dropped off after he returned from the hospital. On 6/30/22 at 12:00 p.m. Surveyor informed DON-B of the concerns R406's coccyx pressure injury not being identified until it was a stage 3 on 5/17/22 and the care plan not revised until 6/3/22. R406's left buttocks pressure injury declined from a Stage 2 to unstageable on 5/24/22 and there was no revision in the skin integrity care plan until 6/3/22. On 6/28/22 the Surveyor observed medihoney being applied to the coccyx & left buttocks wound bed when the physicians order was for collagen. Observations of R406's heels not being offloaded and not wearing the pressure relieving boots. No evidence daily foot inspections were being conducted. On 6/28/22 R406 was identified as having a DTI on right heel. 41439 2.) R400 was admitted to the facility on [DATE] with diagnoses including Senile Degeneration of Brain, Diabetes, Coronary Artery Disease, Osteoarthritis, Cardiomyopathy, and Atrial Flutter. R400's Quarterly MDS (Minimum Data Set), dated 4/12/22 indicated severe cognitive impairment, Bed Mobility required extensive assistance with 2 staff and toileting was dependent with 2 staff. R400's Section M indicated no repositioning program. R400 was identified as being at risk for pressure injury development. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R400's Care Plan, dated 7/9/21, revised 6/16/22, indicated R400 has pressure injury on coccyx with interventions: Administer treatments as ordered (7/9/21), Assist (R400) to reposition and/or turn at frequent intervals (7/9/21) Provide Incontinence care (7/9/21), (R400) requires pressure relieving/reducing device on (Specify:bed/chair) (6/26/22), Weekly Treatment documentation to include measurement, of each area of skin breakdown's width, length, depth, type of tissue, and exudate (6/16/22). R400's CNA (certified nursing assistant) Care card, dated 6/29/22 indicated check and change every 2-3 hours and as needed for incontinence. R400's care card does not address repositioning, heel boots, or an air matress. R400's Assessment record indicated on 6/15/22 at 12:12 PM a Head to Toe skin check identified an open area to coccyx. Facility wound rounds are completed on Thursdays which would be 6/16/22. There is no documentation to indicate R400 was assessed byt he wound team on 6/16/22. R400's Weekly Pressure Injury record was completed on 6/20/22 indicating an Acquired Wound to Coccyx-Stage 2 measuring 1 x 0.7 x 0.1 cm with 100% smooth red wound bed, scant drainage, pink tissue surrounding. Treatment order indicated Medihoney followed by border foam dressing. R400's NP (Nurse Practitioner) Wound Care Assessment on 6/23/22 indicated a coccyx wound measuring 0. 7 x 0.5 x 0.1 cm. Plan of Care/Orders include a pressure reducing cushion to Broda chair, Low air loss mattress, every 2 hours turns with assist and as needed. Treatment: Cleanse with wound cleanser, apply skin prep to surrounding area, Collagen sheet secure with Border foam dressing. No treatment was documented for R400 on 6/25/22. On 6/27/22, at 9:45 AM, Surveyor observed R400 lying flat in bed, heel boots on bilaterally and no air loss mattress. On 6/27/22, at 1:00 PM, Surveyor observed R400 in bed remaining on Back-head of bed elevated with feeding assistance. CNA-J (Certified Nurse Assistance) stated R400 would remain in bed today. R400's Weekly Pressure Injury record was completed on 6/28/22 indicating the acquired wound to Coccyx-Stage 2 measuring 0.7 x 0.5 x 0.1 cm, and documentation indicated a low Air Loss Mattress but it was not observed on the bed. Review of R400's Treatment orders indicate the orders were not changed until 6/28/22 to Collagen per Nurse Practitioner order. R400's Treatment done on 6/28/22 was still documented as Medihoney. R400's care plan was not updated to reflect every 2 hours turns with assist. On 6/28/22, at 8:14 AM Surveyor observed R400 up in Broda chair with cushion in the dining room. On 6/28/22, at 11:54 AM, Surveyor observed R400 remains in Broda chair in dining room for lunch. (continued on next page)

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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	On 6/28/22, at 9:50 AM, LPN-L (Licensed Practical Nurse-Unit Manager) notified Surveyor that R400 remains up in the Broda chair and for Surveyor to observe treatment, the staff would have to lay R400 down. LPN-F stated if R400 wanted to be up for lunch then he would lie down at 1:00 PM otherwise R400 would go to bed for lunch at 11:30 AM. Surveyor stated R400 should be able to choose the care and Surveyor would follow up with R400. On 6/28/22, at 2:00 PM, Surveyor observed R400 in bed lying flat. CNA-I stated R400 went to bed at 1:15PM. R400 was observed on 6/27 for 4 hours without being repositioned in bed. R400 was observed on 6/28 for 5 hours up in chair without repositioning. On 6/28/22, at 2:13 PM, WCRN-F (Wound Care Registered Nurse) stated to Surveyor that R400's dressing changes are T/Th/Sat and Surveyor would need to come right now to see wound and treatment. Surveyor was unable and stated will check with nurse in am to review skin before R400 got out of bed. WCRN-F stated the dressing would probably be soiled and need c [TRUNCATED]