STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525114	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sauk CO Health Care Center	1051 Clark St Reedsburg, WI 53959

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 0684 Level of Harm - Immediate jeopardy to resident health or safety 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** 33166 Based on interview and record review, the facility did not ensure that each resident received, and the facility provided, care and services consistent with professional standards of practice (N6. Wisconsin Nurse Practice Act) for 1 of 5 residents (R4) reviewed for change of condition. R4 presented with a change of condition including decreased appetite (even her favorite foods), abdominal pain, fatigue, nausea, and vomiting. The facility failed to complete a GI (Gastrointestinal)/abdominal assessment and failed to notify R4's physician with R4's complaints of abdominal pain. R4 became lethargic and was transferred to the hospital and noted to have a perforated colon and pneumoperitoneum (the presence of air or gas in the abdominal cavity.) R4 was not a surgical candidate and returned to the facility on hospice services. The facility's failure to recognize a significant change of condition, complete a comprehensive nursing assessment, and notify the physician with a change of condition created a finding of Immediate Jeopardy beginning on 9/27/24. NHA A (Nursing Home Administrator) and the DON B (Director of Nursing) were informed of the finding of Immediate Jeopardy on 10/16/24 at 3:00 PM. The immediacy was removed on 10/16/24 and continues at a severity/scope level of D (potential for more than minimal harm/isolated) as the facility continues to implement its removal plan. This is evidenced by: According to the Wisconsin Nurse Practice Act, N6.03(1), An R.N. shall utilize the nursing process in the execution of general nursing procedures in the maintenance of health, prevention of illness or care of the ill. The nursing process consists of the steps of assessment, planning, intervention, and evaluation. This standard is met through performance of each of the following steps of the nursing process: (a) Assessment. Assessment is the systematic and continual collection and analysis of data about the health status of a patient culminating in the formulation of a nursing diagnosis. (b) Planning. Planning is developing a nursing plan of care for a patient which includes goals and priorities derived from the nursing diagnosis. (c) Intervention. Intervention is the nursing action to implement the plan of care by directly administering care or by directing and supervising nursing acts delegated to L.P.N.s or less skilled assistants. (continued on next page)

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

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	(d) Evaluation. Evaluation is the determination of a patient's progress or lack of progress toward goal achievement which may lead to modification of the nursing diagnosis. According to N6.04(1), In the performance of acts in basic patient situations, the L.P.N. shall, under the general supervision of an R.N. or the direction of a provider . (b) Provide basic nursing care. (c) Record nursing care given and report to the appropriate person changes in the condition of a patient . (e) Perform the following other acts when applicable: 1. Assist with the collection of data. 2. Assist with the development and revision of a nursing care plan. 3. Reinforce the teaching provided by an R.N. provider and provide basic health care instruction. 4. Participate with other health team members in meeting basic patient needs. The facility's policy titled Change of Condition dated 3/2011 states in part; Policy: The shift supervisor will immediately inform the resident, consult with the resident's physician, notify the resident's legal representative, or interested family member when there is an acute change of condition (ACOC) defined as a sudden clinically important deviation from a resident's baseline in physical, cognitive, behavioral, or functional domains. Clinically important means a deviation that without intervention may result in complications or death. Procedure: 1. Identify resident at risk of ACOC and document assessment. An ACOC is reported immediately to the unit supervisor or shift supervisor by the interdisciplinary team member who first notices the change. The unit supervisor collects data on the resident and forwards it to the shift supervisor who completes and documents the nursing assessment. 2. When an ACOC occurs, the shift supervisor will notify the attending physician or designated alternate. If unable to contact either of the above, the Medical Director will be contacted. The resident or the resident's designated medical contact will also be notified. 3. Documentation in the resident's record: the shift supervisor will document the notification of the physician and resident/medical contact along with new orders in the resident's record. 4. For repeated and recurring deviations of vital signs, refusal to take meds, chest pain, or slowly declining condition, the physician may order that the physician only wants to be notified if the change in condition persists or if the deviation exceeds the physician's specific and stated limits. These guidelines must be noted in the physician order. 5. All ACOCs must be documented, and the individual care plan revised to reflect changes in care and treatment. ACOCs will be communicated from shift to shift via shift report, report book and individual unit daily shift reports. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Physical symptoms: Level of Consciousness (LOC): 1. Levels of consciousness are alert, drowsy/lethargic, stuporous, and comatose. 2. The following may indicate an ACOC and should be assessed further: Frequent fluctuations in LOC. A reduction of one level or more of LOC (e.g., from alert to lethargic or from lethargic to stuporous. Hypersomnolence (more sleepy than usual or sleepy for most of the day.) Condition: Acute change in mental status. Report immediately: Sudden onset. Report next day: Gradual onset. Emesis: Report Immediately: greater than 1 episode in 24 hours. Accompanied by abdominal pain and changes in vital signs. Report next office day: single episode. Diarrhea: Report Immediately: acute onset of multiple episodes with change in vital signs and/or altered mental status. Report on next office day: Persistent loose stools for greater than 48 hours while diarrhea is being treated symptomatically. Chronic loose stools. According to https://www.webmd.com/digestive-disorders/what-is-bowel-obstruction: A bowel obstruction is a serious problem that happens when something fully or partly blocks either your large or small intestine. It's also known as an intestinal obstruction. When your digestive system is hindered this way, it can be difficult or impossible to have a bowel movement or pass gas. You might also have stomach pain and a swollen belly. A bowel obstruction is when a section of your intestine is fully or partially blocked. Types of Bowel Obstruction, Doctors divide bowel obstructions into two main types according to their location. Small bowel obstruction About 80% of all bowel obstructions affect the small intestine. A blockage here can keep digested food from reaching your large intestine. Large bowel obstruction, A blockage in your large intestine can slow or stop the passage of poop out of your body. In either intestine, a bowel obstruction can be: Partial. When your bowel is only partly blocked, some gas, food, and liquid can still pass through it. Signs of an intestinal blockage will depend on how serious the obstruction is. But a blockage almost always comes with belly pain, usually around your belly button, and cramps. Other bowel obstruction symptoms include Constipation, Inability to pass gas, Loss of appetite, Nausea or vomiting, A hard, swollen belly, Diarrhea (with a partial blockage), Dehydration. If you've been constipated and have any of these other symptoms, contact your doctor right away. Many people with bowel obstructions are older and may have other serious illnesses, so a bowel obstruction may be life-threatening. According to the National Library of Medicine https://pmc.ncbi.nlm.nih.gov/articles/PMC4535122/ Pneumoperitoneum is the presence of air or gas in the abdominal (peritoneal) cavity. It is usually detected on x-ray, but small amounts of free peritoneal air may be missed and are often detected on computerized tomography (CT).[1] The most common cause of a pneumoperitoneum is a perforation/disruption of the wall of a hollow viscus. The causes of pneumoperitoneum occurring in children are different from the adult population. A gastrointestinal perforation constitutes one of the commonest surgical emergencies. The causes of pneumoperitoneum in adults are perforation .Common signs and symptoms are abdominal pain, vomiting, abdominal distension, constipation, fever, diarrhea, tachycardia (pulse >110/min), hypotension (systolic blood pressure <100 mmHg), urine output (<30 mL/h), and tachypnea (respiratory rate >20/min). R4 was admitted to the facility on [DATE] with diagnoses that include dementia, falls, low back pain, chronic kidney disease stage 3b, and weakness. R4's care plan dated 7/10/24 states in part, dysuria, urine loss due to cognitive impairment. Nurses encourage fluid intake, assess for abdominal distension, assess for UTI (urinary tract infection), monitor I&O (Intake and Output). (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Potential for Comfort Alteration dated 7/10/24 states in part, showing pain behavior, G.I. (gastrointestinal) concerns/problem. (i.e., nonverbal signs of discomfort (crying, moaning, grimacing, guarding). Assess bowel function and provide prescription to promote defecation. Assess pain, quality, location on-set and effective measures. Monitor for lethargy, change in cognitive status, or loss of appetite. Assess physical symptoms. Notify MD as needed. Care Plan Summary dated 7/23/24 states in part, she rarely complains of pain, she is consuming 50-100% of meals. According to meal percentage documentation for September 2024. , R4 ate 25-100% of meals up until 9/21/24 where R4's meal percentages are as follows: 9/21/24 - Breakfast - bites, Lunch-0%, Dinner-25% 9/22/24 - Breakfast - 25%, Lunch-Bites, Dinner-0% 9/23/24 - Breakfast - 50 %, Lunch-0%, Dinner-25% 9/24/24 - Breakfast - 100%, Lunch-50%, Dinner-75% 9/25/24 - Breakfast - bites, Lunch-not charted, Dinner-25% 9/26/24 - Breakfast - bites, Lunch-bites, Dinner-25% 9/27/24 - Breakfast - 100%, Lunch-Bites, Dinner-0% 9/28/24 - Breakfast - 100%, Lunch-Bites, Dinner-75% 9/29/24 - Breakfast - bites, Lunch-not charted, Dinner-75% R4's BM (Bowel Movement) record is as follows: 9/21/24 - No BM 9/22/24 - Large Formed 9/23/24 - No BM 9/24/24 - Small loose 9/25/24 - Medium loose 9/26/24 - Large (does not specify consistency) 9/27/24 - Large loose x3 9/28/24 - Medium (does not specify consistency) (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	9/29/24 - Large (does not specify consistency) Of note, from 9/24/24 to 9/29/24, R4 had several loose BMs which can occur with a SBO (Small Bowel Obstruction). R4's weights were as follows: 7/12/24 - 172.8 (Admission weight) 7/25/24 - 176.8 8/17/24 - 175.0 8/30/24 - 175.4 9/2/24 - 177.0 9/26/4 - 171.0 (R4 lost 3.35% of her weight in 24 days) R4's nursing progress notes state the following: 9/9/24 at 15:43 (3:43 PM) usually amount eaten varies 50 to 75%. Has a fair appetite, resident reports feeling satisfied and full. 9/9/24 at 15:44 (3:44 PM) is incontinent of bowel more than 3 times per week. Bowel elimination pattern is regular (at least one movement every 3 days). 9/21/24 at 00:05 (12:05 AM) having nausea tonight no emesis. Refused 7-Up. Continue to observe. 9/23/24 at 16:12 (4:12 PM) Tums 500 mg (milligram) tablet given for GI upset. 9/26/24 at 00:31 (12:31 AM) resident coughing and had a small emesis of undigested food at 200 [sic]. Oral care given and sips of water. No further emesis. 9/26/24 at 13:41 (1:41 PM) Late Entry for 9/25/24 physician visit and examined. Physician Progress Note dated 9/25/24 states in part: nursing staff notes the following concerns or recommendations: none. The patient reports the following concerns: none. General appearance: not in acute distress. Appearance: Normal appearance. Not ill-appearing. The physician completed the following exam HENT (Head/Ear/Nose/Throat): Head normocephalic - Pulmonary: Pulmonary effort normal - Musculoskeletal: Cervical Back: Neck supple. Neurological: Mental Status: she is alert and Psychiatric: Mood and Affect: Mood Normal. Behavior: Behavior Normal. It should be noted according to the progress note dated 9/25/24 there is no evidence the physician completed an abdominal/GI assessment. R4's nursing progress notes state the following: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	9/27/24 at 14:27 (2:27 PM) Blood Pressure: 112/74, resident complains of fatigue, lethargy (mild pain), abdominal. Resident's face was flushed most of the day. Resident had a large, incontinent BM after lunch today. Resident had flu shot 1-2 days ago and his [sic] may be side effects. Resident did lay down in the afternoon after lunch, warm blanket put over her abdominal area. No further complaints at this time lying down. The facility 24-hour board (nursing report between shifts) for R4 states in part: 9/27/24 AM shift - increased weakness, fed 100%. There are no entries for PM or NOC shift. It should be noted on 9/27/24, R4 was noted to have abdominal pain, fatigue, lethargy, a loose stool, and bites for lunch. Despite these signs and symptoms of a change of condition there is no evidence the facility completed an RN assessment. R4's nursing progress notes state the following: 9/28/24 at 12:45 PM Tums 500 mg tablet chewable. The facility 24-hour board for R4 states in part: 9/28/24 AM shift - not eating well, afebrile. PM shift - Refused meal did not get OOB (out of bed). 9/29/24 at 14:36 (2:36 PM) call placed to on-call (physician name) regarding COC (change of condition). New orders received obtain CBC (Complete Blood Count), CMP (Complete Metabolic Panel), UA (Urinalysis) culture if indicated. It should be noted there is no documentation or assessment in the nursing notes indicating what the COC was for R4. The last nursing note indicating symptoms was dated 9/27/24, two days earlier. 9/29/24 at 15:51 (3:51 PM) spoke with on-call (physician name) regarding lab results BUN (Blood Urea Nitrogen). (A laboratory test that test the amount of urea nitrogen in your blood, which can indicate how well your kidneys are functioning. A normal BUN is 6-21mg/dl (milligrams per deciliter)). Lab results: BUN 123 (An elevated BUN can be signs of kidney problems.) It should be noted R4 has a history of stage 3b chronic kidney disease meaning she has moderate to severe loss of kidney function. The 24-hour board for R4 dated 9/29/24 states in part; AM shift - emesis again today, afebrile, not eating or drinking. Received orders for UA, Comp panel. PM Shift - Sent out. R4's nursing progress notes state the following: 9/29/24 at 16:09 (4:09 PM) states in part; resident transferred 9/29/24. Time of Transfer: 16:30 (4:30 PM). Transferred to: (Hospital Name). Reason: for evaluation, COC. Primary sign/symptom leading to transfer: abnormal labs, or test, altered mental status, nausea/vomiting, nutrition (inadequate intake food/fluid). Primary diagnosis/presumed diagnosis leading to transfer: dehydration, failure to thrive, BUN 123. 9/29/24 at 22:43 (10:43 PM) spoke with ER (emergency room) Regarding: admitted for AKI (Acute Kidney Injury). (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	EMS (Emergency Medical Services) report dated 9/29/24 states in part; report response: emergency response. Unit notified dispatch: 9/29/24 16:36 (4:36 PM). Primary Symptom - Malaise. Other Associated Symptoms - Abdominal rigidity, Nausea, Vomiting. Primary Impression: GI/GU (Genitourinary) - Nausea (w/vomiting). Patient Care Report Narrative: Ambulance dispatched to (Facility Address) with COC. En route immediately and upon arrival at the scene, we were met in hallway by nurse and directed us to patient room. Upon entering room, EMS found a patient lying supine in bed with her eyes closed. Her daughter was in the room as well, talking to another nurse that was standing at the patient bedside. Daughter stated that the patient has been having nausea and vomiting over the last couple of days and today she is very lethargic. Patient has a history of dementia and the daughter states she is a DNR (Do Not Resuscitate). Appears to be in no obvious signs of distress but is very lethargic. Abdomen is distended and rigid with reports of nausea and vomiting over the past couple of days, unable to keep anything down. Once placed in ambulance patient was hooked to cardiac monitor showing an irregular rhythm with first degree heart block (slow conduction of heart) was obtained with a 12-lead ECG (Electrocardiogram). Patient was given 150 ml (milliliter) of LR (Lactated Ringers) for hypotension (low blood pressure). Vital Signs Recorded with EMS: 9/29/24 at 16:52 (4:52 PM) BP (blood pressure) 77/57 (low bp), Pulse: 88, Respirations: 16, Oxygen Saturation: 96%. Temperature: 97.4 9/29/25 at 17:03 (5:03 PM) 75/56, Pulse 65, Respirations: 16, Oxygen Saturation: 96%, Temperature: 97.4. Of note, the paramedics' assessment indicates R4 was lethargic with a distended abdomen and nausea and vomiting the past couple of days. However, there is no indication or documentation in R4's medical record of an abdominal assessment by the facility despite presenting with GI symptoms. Hospital History and Physical dated 9/29/24 states in part; Chief Complaint: presents with fatigue and vomiting. Presents with nausea, vomiting and poor p.o. (oral) intake. Her daughter states that for the past week, she has been having vomiting after she tries to eat or drink. In addition, the past several days she has been feeling fatigued, lethargic, and complaint of dull, intermittent lower abdominal pain. She has been sleeping most of the day. According to the EMR (electronic health record) notes, patient has been having decreased urine output for an unspecified period of time. Nursing home staff noted her BP (blood pressure) had been low and contacted EMS. There are no reports of fever, chills, constipation, diarrhea, hematuria (blood in urine), urgency, chest pain or URI (upper respiratory illness) symptoms or shortness of breath. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	ED (Emergency Department) Findings: In the ED, she was severely hypotensive (low blood pressure). She received 2 liters of normal saline bolus with minor improvement. Her lab work showed marked prerenal azotemia (a condition that occurs when there is a buildup of nitrogen waste products in the blood due to decreased blood flow to the kidneys) with a BUN of 123 and Creatinine of 2.4. Urinalysis was positive for nitrates, leukocyte esterase, and bacteria (sign of infection). She was given 2 grams of IV (Intravenous) Rocephin (antibiotic). An x-ray of the abdomen showed findings consistent with SBO (small bowel obstruction) and bowel perforation. ED provider called the on-call general surgeon. Given her advanced age and comorbidities, she would not be a candidate for surgical intervention. I discussed goals of care with her daughter. They wish for her to be DNR (Do Not Resuscitate) (No life saving measures). They do not wish to pursue any aggressive intervention, such as pressors (medication to increase blood pressure), intubation (tube inserted to assist with breathing) or surgery. She will be admitted for comfort care and hospice consult. Reason for Admission: SBO with perforation. Vital signs in ED: BP: 63/41 (Critically low), P (Pulse): 83, T (Temperature): 97.7, R (Respirations): 18, Oxygen Saturations; 95 % Constitutional: General: She is sleeping. In no acute distress. She is ill-appearing. Abdominal: General: Bowel sounds are increased. There is distension. Palpations: Abdomen is soft. Tenderness: There is guarding. There is no rebound. Results Review: Labs: CMP (Compete Metabolic Panel) shows azotemia with creatinine of 2.4 (elevated) (A creatinine level is a measurement of the amount of creatinine in your blood or urine and is used to evaluate your kidney function. Normal range 0.6 -1.1. elevated range can indicate decreased kidney function.) and BUN 123 (elevated). This is consistent with prerenal AKI (Acute Kidney Injury) (a sudden decline in kidney function). WBC (White Blood Cells) WBC: 10.4 (slightly elevated) (Indication of infection). UA (Urinalysis) was positive for nitrate and leukocyte esterase (indication of urinary tract infection). Imaging: x-ray of abdomen shows dilated bowels consistent with small bowel obstruction. Pneumoperitoneum is seen, suggesting bowel perforation. Plan: Given her assessment findings, it is likely that she is approaching end-of-life. We will implement comfort measures accordingly per family wishes. Prognosis: Death expected. R4's abdominal x-ray dated 9/29/24 at 1719 (5:19 PM) states in part; Indication: vomiting and hypoxia. Technologist Note: pain, vomiting and hypoxia. Findings: Dilated, gas-filled small bowel loops, measuring up 4.4. cm (centimeters), suspicious for a SBO (small bowel obstruction). Pneumoperitoneum, suggesting bowel perforation. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Discharge Summary dated 10/2/24 states in part; discharge diagnosis and hospital problems: small bowel obstruction, nausea with vomiting, AKI (a sudden decline in kidney function), hypotension, acute cystitis without hematuria (inflammation of the bladder without bleeding) and early onset dementia. Summary of hospitalization presents last night with lethargic [sic], nausea, vomiting and poor p.o. (oral) intake. Patient was found to have evidence of SBO and bowel perforation. admitted for comfort care. Today being discharged back to nursing facility for transition to hospice. Nursing Home Progress notes dated 10/2/24 at 23:23 (11:11 PM) state in part; came back to facility to be taken care of Hospice [sic] due to diagnosis of SBO and perforation. On 10/16/24 at 7:12 AM, Surveyor interviewed CNA L (Certified Nursing Assistant) regarding R4. Surveyor asked CNA L how R4 appeared days prior to her hospitalization . CNA L stated R4 had a distended stomach, not acting herself, we all knew something was wrong with her. CNA L stated her appetite decreased and she was just not herself. Surveyor asked CNA L what she means that R4 was not herself. CNA L stated she wasn't eating well, she had the distended abdomen, was nauseated and vomiting, and just not her alert, cheerful self. Surveyor asked CNA L if she told anyone about how R4 was presenting. CNA L stated yes, I reported it to the nurses; CNA L was not able to recall what nurses she reported it to. On 10/16/24 at 7:25 AM, Surveyor interviewed CNA K regarding R4. Surveyor asked CNA K how R4 appeared days prior to her hospitalization . CNA K stated R4 would not eat, she was eating less, more withdrawn, would call out at times which was unusual for her, and she complained of some abdominal pain. Surveyor asked CNA K if she told anyone about R4's behavior, CNA K stated the nurses were aware she was not eating much and more withdrawn. On 10/16/24 at 7:00 AM, Surveyor interviewed Agency LPN F (Licensed Practical Nurse) regarding R4. Surveyor asked LPN F how R4 appeared days before she was hospitalized . LPN F stated R4 was slowly declining, she was yelling out, then that stopped. She was not eating for several days, not drinking, wouldn't even drink her coffee, she loved her coffee, she was like a shell in her chair. Surveyor asked if R4 complained of abdominal pain, LPN F stated not sure if she could. No real nausea/vomiting when I was working. LPN F stated, I just thought she was declining due to her advanced age. LPN F stated a few days or so ago, prior to her hospitalization , we noticed she was just not herself. Surveyor asked LPN F what she noticed was different. LPN F stated she was just out of it, very sleepy, not eating, not drinking. LPN F stated, I never thought she was sick. Surveyor asked LPN F if a resident is presenting with nausea/vomiting, abdominal pain, and lethargy what would she do. LPN F stated I would let the Dr. know. Surveyor asked if LPN F would have an RN assess a resident with these complaints, LPN F stated yes. On 10/16/24 at 7:20 AM, Surveyor interviewed LPN N regarding R4. Surveyor asked LPN N how R4 appeared days prior to her hospitalization . LPN N stated R4 was weaker, quieter, withdrawn. LPN N stated she was usually more cheerful. Surveyor asked LPN N if she noticed a COC with R4. LPN N stated not until 3-4 days prior to her hospitalization it was obvious something was not right, we were just not sure what was occurring. Surveyor asked when a resident is presenting with a COC or just not seeming right what would you do. LPN N stated let the charge nurse know of the concerns. Surveyor asked LPN N if she reported the concerns she was seeing to the charge nurse. LPN N stated the charge nurse was aware. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 10/16/24 at 7:30 AM, Surveyor interviewed RN I (Registered Nurse)/Nurse Supervisor regarding how R4 appeared days prior to her hospitalization . RN I stated R4's appetite was poor, she was more lethargic, more tired, just feeling punky. Surveyor asked RN I how long R4 presented this way prior to hospitalization . RN I stated probably 2-3 days. RN I stated R4 had constipation issues and we were monitoring her bowel sounds and abdomen. Surveyor asked RN I where Surveyor could find the assessments for R4, and RN I stated they would be in the medical record under nursing progress notes. On 10/16/24 at 10:45 AM, Surveyor interviewed Agency RN M regarding R4. Surveyor asked RN M how R4 appeared days prior to her hospitalization . RN M stated, the day I sent R4 out to the hospital she was not eating, was more lethargic, had an emesis and a large BM on my shift. I called the Dr. on-call as she was not feeling well for a few days. I received an order to complete labs and her BUN was elevated so we sent her out. RN M stated she had an altered mental status, did not have much intake so R4 was sent to the hospital, and they found she had a SBO and UTI. Surveyor asked RN M did you complete an assessment on R4 when she was presenting this way. RN M stated she did not recall completing an assessment. R4 just could not get fluids in, was lethargic, and not talking. On 10/16/24 at 1:50 PM, Surveyor interviewed RN O regarding R4. RN O stated she worked on Saturday 9/28/24, and R4 had an emesis 1 day prior to 9/29/24. RN O stated R4 had a good day on 9/28/24. RN O stated gradually R4 was not eating the way she had been. She complained some of GI upset and received Tums. RN O stated on 9/29/24, R4 did not want to get out of bed, we knew something was not right and we called Dr. and received orders for labs and UA. RN O stated, I did not have concerns; except she was not eating like normal and knew something was brewing just not obvious. Surveyor asked RN O if during the time R4 had a decreased appetite, not feeling well, did she complete a GI assessment. RN O stated no, I didn't recognize anything out of the ordinary. On 10/16/24 at 10:50 AM, Surveyor interviewed DON B (Director of Nursing) regarding R4. Surveyor asked DON B what the facility was aware of prior to R4 being sent to the hospital. DON B stated R4 had just recently received the flu shot and told staff to monitor residents for potential reactions to the flu vaccine, we thought it was the flu vaccine. Surveyor asked DON B to review R4's nursing progress notes. DON B stated, I see on 9/27/24 she was more lethargic, flushed, had a large BM, and we were monitoring her. On 9/28/24, there was nothing charted. On 9/29/24, she was not eating and decided to get labs to see how R4 was doing. Labs were abnormal, R4 had an emesis, and she was sent out. DON B stated, it seems to me like R4 was an erpy person, meaning having small emesis. DON B stated R4 was not a big eater, ate small amounts and always had. DON B stated I know she had a SBO, but she was still pooping and eating at baseline. Surveyor asked DON B what standard of practice the facility follows for COC and MD notification, DON B stated Interact. Surveyor asked DON B about the nursing note for 9/26/24 for R4. Surveyor discussed the progress notes, 24-hour board, staff interviews regarding R4 and asked DON B on 9/27/24 when the nurse documents R4 presented with abdominal pain, fatigue, and lethargy, what would your expectations be. DON B stated she would hope for a GI assessment and to call the MD. DON B stated it was a small emesis of undigested food and she was coughing; this was R4's baseline. Surveyor asked DON B if the facility has a morning stand-up (staffing meeting) and DON B stated yes. Surveyor asked DON B if R4 was brought up at the stand-up meeting. DON B stated, I think R4 was a long-term erpy resident and this was not abnormal. Surveyor asked DON B when looking over R4's symptoms for the 2-3 days prior to R4's hospitalization would you expect the nursing staff to complete an RN assessment? DON B stated 100 percent if having abdominal pain. DON B stated there was nothing out of baseline for R4, we had no idea she had a COC until the day the labs were drawn then we realized something was occurring. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525114	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sauk CO Health Care Center	1051 Clark St Reedsburg, WI 53959

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 10/16/24 at 11:50 AM, Surveyor interviewed R4's physician MD P (Medical Doctor) regarding R4's COC. Surveyor asked MD P if she would expect to be notified if a resident presents with nausea, vomiting, abdominal pain, and lethargy. MD P stated she would expect the nursing staff to contact her with a full assessment. Surveyor asked MD P if this would include things such as listening to bowel sounds, palpating the abdomen, full set of vital signs, MD P stated yes. MD P stated if it were just nausea we could give an antiemetic (medication for nausea), continue to monitor and escalate care if exam shows other finding such as nausea, vomiting, abdominal pain, and lethargy. MD P stated if R4 was presenting with nausea, vomiting, abdominal pain, and lethargy, the facility should have notified the physician on-call. R4 presented with decreased appetite, nausea, vomiting, abdominal pain, and lethargy. The facility failed to recognize R4's change of condition, failed to complete a GI/abdominal assessment, and failed to notify R4's physician with R4's complaints of abdominal pain. R4 became lethargic and was transferred to the hospital and noted to have a perforated colon and pneumoperitoneum. The facility's failure to recognize a change of condition, complete a comprehensive nursing assessment, and notify the physician with a change of condition created a reasonable likelihood for serious harm, thus leading to an immediate jeopardy situation which began 9/27/24. The facility removed the immediate jeopardy on 10/16/24 by taking the following actions: DON and ADON (Assistant Director of Nursing) did a complete facility wide sweep to determine if any residents had a COC. Any residents identified with a COC had an immediate nursing assessment completed and MD/POA (Power of Attorney) updated. DON and ADON reviewed the 24-hour report to confirm accuracy and to identify any other residents with a potential COC. DON educated nursing staff and reiterated the importance of completing accurate nursing assessments and documentation in a timely manner. Including education on what to include in a thorough GI/digestive assessment and how to interpret the results. If assessment is abnormal, following with COC protocol including MD/POA notification. All staff received immediate education prior to their next working shift on the following: o Change of Condition o Nursing Documentation/Assessment o MD/POA Notification o 24-hour report should be brought to morning clinical meeting and afternoon stand down (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525114	A. Building B. Wing	10/30/2024

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	o 24-hour reports should include, but are not limited to: resident COC, follow up assessments, negative behaviors, pressure injuries, falls, resp/GI symptoms admissions, discharges, room changes, appointments, MD rounds, new orders, care plan changes, medication changes, therapy updates, refusals, change in functional and cognitive status Audits will be completed on all the above items. Findings will be presented at least quarterly at QAPI. o On October 17, 2024, nurses and CNAs were given Skills Assessment sheets to determine what area of focus is needed to perform job duties effectively. DON and/or ADON will review Assessment sheets, educate

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	525114	A. Building B. Wing	10/30/2024

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36192 Based on interview and record review, the facility failed to ensure each resident (R) received adequate supervision to prevent accidents for 1 of 3 residents (R1) reviewed for falls. On 9/2/24, R1 was in the shower room when CNA D (Certified Nursing Assistant) attempted to remove R1's incontinent product from under her while she was sitting in the shower chair. This caused R1 to begin to fall. CNA D and CNA E assisted R1 to the floor. When a nurse had not shown up for 15 minutes, CNA D & CNA E assisted R1 off of the floor prior to a nurse assessing R1 for any type of injury. From the fall incident on 9/2/24, R1 sustained a fracture to her right tib/fib. On 10/4/24, R1 had an x-ray completed that showed an angulated and displaced left femur fracture. R1 was sent to the hospital on 10/14/24 related to R1 now having an open fracture of the left femur. The facility's failure to prevent accidents from occurring due when CNA D and CNA E attempted to remove an incontinent product while R1 was in a shower chair and then transferring R1 without a nurse assessment resulted in a right tib/fib fracture and a left angulated and displaced femur fracture. These failures created a finding of immediate jeopardy that began on 9/2/2024. NHA A (Nursing Home Administrator) and DON B (Director of Nursing) were notified of the immediate jeopardy on 10/16/24 at 3:00 PM. The immediate jeopardy was removed on 10/16/24, however the deficient practice continues at a scope/severity of D (potential for more than minimal harm/isolated) as the facility continues to implement their removal plan. Evidenced by: Facility policy titled Fall/Accident Prevention, states in part: .Resident/client will receive adequate supervision and assistive devices, based on the comprehensive assessment to prevent accidents and falls. The facility will identify residents at risk for falls/accidents and adequately plan care and implement procedures to prevent falls . 1 .Appropriate interventions will be implemented for each resident to prevent falls/accidents based on individual resident need . All residents will be assessed on an individualized basis and will receive adequate supervision appropriate assistive devices will be provided to prevent accidents and falls .Assistive devices will be assessed for appropriateness, safety, and teaching of use provided In addition, CNA care cards and ICP will also reflect residents' extreme high risk for falls .2. After each fall, the nurse will implement a temporary fall CP (care plan) times 72 hours and complete a fall assessment in the nursing notes. Assessment should include date, time, location of fall, circumstances of the fall including circumstances are root cause leading to the fall/accident, (such as meds or wet floor) witnessed, unwitnessed, injuries, pain, interventions to prevent further falls and treatment provided .MD (Medical Doctor) will be updated on all falls with significant injury and incident will be reported to responsible party immediately if injury and within 24 hours if no injury .5. An accident report (for internal use only) will be completed by the neighborhood nurse or supervising nurse with each fall. The DON, Administrator, and medical director will receive a copy of the incident for follow-up and evaluation if needed. The resident is placed on 24-hour report for 72 hours for follow-up by nursing. Unwitnessed falls without a root cause identified will be investigated per facility Policy and Procedures . (continued on next page)

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	525114	A. Building B. Wing	10/30/2024

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Per John Hopkins, The femur is the large bone in the upper part of your leg. Different kinds of trauma can damage this bone, causing it to fracture into 2 or more pieces. This might happen to the part of the femur near your knee, near the middle of the femur, or in the part of the femur that forms part of your hip joint. In certain types of femur fractures, your femur has broken, but its pieces still line up correctly. In other types of fractures (displaced fractures), the trauma moves the bone fragments out of alignment. (https://www.hopkinsmedicine. org/health/treatment-tests-and-therapies/femur-fracture-open-reduction-and-internal-fixation) R1 was admitted on [DATE], with diagnoses that include anemia, bilateral primary osteoarthritis of knee, chronic peripheral venous insufficiency, anxiety disorder, abnormal coagulation profile, and age-related osteoporosis without current pathological fracture (5/10/23). R1's significant change MDS (minimum data set) dated 9/10/24, indicates R1 is severely cognitively impaired and has impairment on one side of her lower extremities. R1 is dependent on staff for eating, toileting, showers, transfers, and dressing. Section J includes R1's staff pain assessment, which indicates R1 has shown nonverbal signs of pain including, facial expressions, and protective body movements which have been observed daily. R1 is indicated as not having any falls since prior assessment. CNA D's (Certified Nursing Assistant) witness statement dated 9/2/24 indicates: Name of victim (R1). Was the victim injured, yes is marked. What happened? While giving a shower to (R1), I (CNA D) tried to pull the brief (incontinent product) out from under her bottom so that I could wash her bottom. In doing so, (R1) started to slip from the shower chair, to prevent a fall the other CNA (CNA E's name) and I lowered (R1) to the floor. She did not hit her head and to my knowledge at this point, I thought we were careful to not hit any of her extremities. we pulled the emergency call button. While we were waiting for the nurse we covered her in bath blankets and waited. After 15 minutes I (CNA D) grabbed the Hoyer lift and used it to lift (R1) from the floor to her reclined Broda chair. I then wheeled her down to her room and the nurse and I hoyered her to her bed. While I was getting her dressed in a gown I noticed that her leg looked off. I immediately notified the nurse to check her leg for injury. When did it occur? (date and time) 9/2/2024 8:45 PM. On 10/15/25 at 11:30 AM, Surveyor interviewed CNA D regarding R1's fall in the shower room. CNA D indicated that when R1 is in the shower she gets cold, so CNA D swaddled/wrapped her up in blankets and did not see she still had her incontinent brief on. CNA D indicated R1 was transferred to the shower chair and CNA D noticed R1's brief was still on. CNA D indicated she tried to pull it down through the hole, I shouldn't of. CNA D indicated her and CNA E lowered R1 to the floor and got her into the wheelchair with the hoyer and the nurse came in, then we transferred her to the bed. CNA D indicated while getting R1 dressed she called the nurse back in and noticed her leg was broken. CNA D stated, I was in a rush, as they're always short staffed. CNA D indicated we pulled the emergency cord and it was cold in there, she (R1) was crying. CNA D indicated R1 had a brace after the incident to her right leg and rolling her was hard to do for cares. CNA D indicated they put a pillow between her legs when moving and rolling her back and forth. CNA D indicated R1's left leg was fine and did not notice anything wrong with her left leg. (continued on next page)

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	525114	A. Building B. Wing	10/30/2024

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	CNA E's witness statement dated 9/2/24 indicates: Name of victim (R1). Was the victim injured? Yes is marked injury to the leg. What happened? (CNA D) attempted to get brief off of her in the shower chair to try (and) wash her bottom. She slipped out of the shower chair. So we lowered her down to floor. We pulled the emergency cord. We waited for 15 minutes. She was very vocal while on the cold shower floor. She had blankets under her head and ankles. We hoyered her from the ground into her wheelchair. We were finally able to get a nurse, she came (and) we took her into her room. Where the nurse checked her out. When did it occur? Around 8:45 PM on September 2nd 2024. On 10/15/24 at 3:58 PM, Surveyor interviewed CNA E regarding the incident with R1. CNA E indicated they got R1 into the shower chair, and halfway through realized her brief/incontinent product was on. CNA D tried to get it out, when tried to rip it, it pulled her bottom off the chair and we couldn't get her back on the chair. CNA E indicated CNA E and CNA D lowered R1 to the floor, clicked on the emergency light. CNA E couldn't find the nurse, so CNA D said, Ok let's get her up. CNA E indicated they got R1 up into her shower bed or chair, got another nurse. CNA E indicated the nurse didn't get the page for the emergency light for the spa room. CNA E indicated CNA D helped get R1 up off the floor using the hoyer lift (full body) and then put more blankets on R1. CNA E indicated they waited approximately 15 minutes before getting her up off the floor. CNA E indicated R1 didn't look in pain after the nurse assessed her, she was asleep. CNA E indicated CNA E looked for their nurse but couldn't find the nurse, so CNA E went and got LPN F. CNA E indicated R1 went out to the hospital and came back with a pillow between her legs, not to lay on her right side, assist with meals and to keep a pillow between her legs when she was up. LPN F's (Licensed Practical Nurse) witness statement dated 9/2/24 indicates: Name of victim: (R1). Was the victim injured? Yes is marked. What happened? (CNA E's name), CNA came over to (unit name) stating they need a nurse and can't find (name of unit) nurse, that they have had the emergency light on in (unit name) spa for 15 min. When writer arrived at spa, resident was in her Broda chair. (CNA D), CNA stated that resident was lowered to the ground after discovering that they did not remove resident's brief and resident slipped out of chair. CNAs stated that they put resident back in chair because of resident being on the floor for 15 min already. Writer tried to get vitals but resident too contracted. (RN G) floor nurse came (and) took over. On 10/15/24 at 2:40 PM, Surveyor interviewed LPN F (Licensed Practical Nurse) regarding R1's fall. LPN F indicated she was working on another unit when an aide came running over to get her. LPN F indicated she went into the spa room and assessed her and that R1 doesn't talk, she didn't know anything was broken, R1 was very rigid and anxious. LPN F indicated R1 was on the floor when she went to the spa room. (of note: CNA D and CNA E indicated they moved R1 before the nurse assessed and LPN F's witness statement indicates R1 was moved prior.) LPN F indicated R1's legs are always contracted. LPN F indicates she did not know she had to call a nursing supervisor with a fall, and RN G took over. RN G's (Registered Nurse) witness statement dated 9/2/24 indicates: Name of victim: (R1). Was the victim injured? Yes is marked left lower leg swelling & bruising. What happened? Aides reported after resident in bed that her left leg looked weird. (LPN E) nurse, wrote note on my wing sheet that resident had been lowered to floor in shower room. Per CNAs resident had slipped when attempting to remove brief. When did it occur? 2100 (9:00 PM) 9/2/24. (continued on next page)

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	525114	A. Building B. Wing	10/30/2024

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 10/15/24 at 2:57 PM, Surveyor interviewed RN G regarding R1. RN G indicated she was working that unit that night and when the fall occurred she was in doing a treatment on another resident. RN G indicated when she came out of that room she had a note R1 had fallen. RN G indicated when she got to R1 she was in bed and you could see bruising and swelling. RN G indicated she called the charge nurse and sent R1 out to the hospital. RN G indicated that when R1 came back from the hospital, she had a splint on her Right right leg and had to keep it locked at 60 degrees and provide support to the leg as much as possible. R1's Purposeful Post-fall Huddle, conducted on 9/2/24 indicates the following: Resident (R1), date of fall: 9/2/24, time of fall: 2045 (8:45 PM), day of week: Monday. Date of huddle: 9/2/24, time of huddle: 2230 (10:30 PM). Resident: what were you trying to do? CNA was attempting to remove brief from resident while resident was still in shower chair. Root Causes: 1. CNA attempting to remove brief from resident while resident was sitting in shower chair. Action plan: What can be done to avoid future falls (interventions)? Use shower bed chair. On 9/2/24, R1's Progress notes are as follows: At 22:20 (10:20 PM) R1's Nurses note states in part: .Transferred to: (Hospital name). Transportation: by ambulance.Reason: for evaluation.Primary sign/symptom leading to transfer: Fall(s) Pain (uncontrolled) Trauma (fall-related or other) . At 22:20 (10:20 PM) R1's Nurses note states in part: .Transfer: two assist with Hoyer needs 2 assist. Notification: ER notified and given report, administrator notified, DON (Director of nursing) notified, SW (social worker) notified, ambulance called, physician notified, family notified daughter (name). At 23:04 (11:04 PM) R1's Nurses note states in part: .Skin problems: Left lower leg, below the knee swelling and start of bruising noted, after being assisted to the floor during a shower. 4 1/2 x 5 3/8 swelling and bruised area. Per CNA, resident lowered to the floor in shower room by 2 after slipping while attempting to remove brief. Aat 23:12 (11:12 PM) R1's Nurses note states in part: Comments: Resident suffered left leg injury while showering. EMS called for transport to (Hospital Name). Left facility at 2305 (11:05 PM) with patient left leg stabilized with blue foam splint and towels. Assisted to EMS cot with 4 . {sic} At 23:32 (11:32 PM) R1's Nurses note states in part: Note: Resident was in the shower room with a staff member when she started to slip off of the shower chair and was lowered to the floor. Resident was lifted off the floor using a hoyer lift by two CNA's. Then the resident was placed in her w/c (wheelchair), transferred to her room and hoyer lifted into bed by CNA and LPN. Writer was called by assigned LPN to assess resident at this time. Resident's right leg is swollen from her foot to her knee and is becoming bruised. There is a large, raised area distal to the knee measuring 4 1/2 x 5 3/8 inches. Resident is moaning/crying in pain. (Physician Name) ordered transfer to hospital . At 23:55 (11:55 PM) R1's Nurses note indicates R1's Healthcare Power of Attorney (HCPOA) was called regarding a fall and injury. (continued on next page)

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	525114	A. Building B. Wing	10/30/2024

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 10/16/24 at 10:10 AM, Surveyor interviewed DON B and NHA A regarding the incident with R1. DON B indicated she started an investigation and CNA D and CNA E both said they made a mistake as they took R1 to the shower room in the chair, noted the brief was on and instead of taking R1 back to her room they tried to take it off of her in the chair, R1 began to slide out, they noted sliding and lowered her. DON B indicated they activated the emergency light in the shower room and R1 was cold on the floor, so they covered her up with blankets. LPN F assessed and R1 was in bed when noted leg wasn't right. RN G had a note of R1 falling, then RN G assessed and noted R1's leg. NHA A indicated the fall occurred around 2045 (8:45 PM). Surveyor asked DON B and NHA A both to read the witness statements from CNA D, CNA E, and LPN F regarding R1's fall. Surveyor asked if they were aware that R1 was moved off the floor without a Nurse assessing R1 first. DON B replied the staff get an RN to assess her to ensure no internal/external rotation and the RN gives the okay if the resident can get up or not. DON B indicated they do a fall investigation which looks at the root cause of what happened, what caused it, what was happening etc., and it's reviewed by the IDT (interdisciplinary team) to review interventions are appropriate to fix it and notifications were done to the MD and representative/family. DON B indicated she individually met with CNA D, CNA E, and LPN F. DON B indicated CNA D and CNA E said the call light was on and felt like 15 minutes had gone by. DON B indicated LPN F indicated she assessed R1 and DON B educated LPN F that LPNs cannot assess. DON B indicated that a nurse should have done an assessment before moving R1. DON B indicated she educated CNA D and CNA E on what to do if it occurs again before transferring resident to check brief is off or take back to the bed/room to take brief off. DON B indicated this was an isolated event and verbal education was done with CNA D. Surveyor asked DON B for documentation of verbal education, DON B indicated she does not have anything. On 9/2/24 at 11:24 PM, R1's Emergency Department (ED) note indicates: R1 received a CT of cervical spine, CT chest, abdomen, pelvis, CT angio of right lower extremity. Clinical impression: Fall, right tibial plateau fracture with some tibial posterior displacement, fibular neck fracture, elevated white count and hypoxia. On 9/3/24 at 6:53 AM, R1's Nurses note states in part: .resident has been admitted to the hospital with a tib-fib fracture . On 9/3/24 at 11:36 AM, R1's 'Physician Discharge Summary,' states in part: .Principal problem: Closed fracture of right tibial plateau.Presentation: (R1) is a resident at (Facility name). She is normally bed-bound and requires maximum assistance assistance [sic] with hoyer lift. Earlier this evening, the CNAs had placed her on a shower chair. They were attempting to take off her brief to get her in the shower and she ended up having a fall on the bathroom floor . ED findings: in the ED, she was in a lot of pain and was crying out. Her right leg appeared swollen and painful but pulses were present. Reason for admission: Inpatient status for closed fracture of right tibial plateau secondary to fall. Hospital course . Ortho evaluated the patient and recommended a brace placement. Patient will be sent back to SNF (skilled nursing facility) with increased pain medications. On 9/3/24 at 15:03 (3:03 PM,) R1's Nurses note indicates R1 was readmitted to the facility at 1:40 PM. On 10/4/24 at 3:06 PM, R1's Radiology report states in part: results: recent fracture involving left distal femur with moderate angulation and displacement. The joint shows no dislocation. There is diffuse osteopenia and moderate degenerative changes left knee. Conclusion: Recent fracture involving left distal femur with moderate angulation and displacement. (continued on next page)

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	525114	A. Building B. Wing	10/30/2024

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 10/4/24 R1's Orthopedic NP note written by NP C, states in part: .at approximately 1630 (4:30 PM) writer was notified of the radiography results.subsequently went to the (name of facility) in person to view the radiographs on (company name) website. After review of the imaging, writer evaluated (R1). (R1) is up in her Broda chair and is eating supper in the dining room. She does not appear to be in any distress . The left knee was intact, but had a large circular red/purple area that was covered with a mepilex foam dressing for protection. The overlaying skin was intact, but upon palpitation of the area, the end of the femur could be palpated. (R1) did not show signs of pain during the exam.Staff deny any falls, trauma or injury other than the fall on 9/2/24 for which (R1) was hospitalized for a right tibial plateau fracture. No injury to the left knee or leg was noted and no imaging was obtained during that hospitalization . On 10/1/24, Nursing staff (Name) notified (R1's) primary care provider of a concerning [sic] a nodule to the left knee, approximately the size of a grape. No warmth was noted and no signs of pain were reported. A foam dressing was applied for padding of this area and a pillow was placed between her knees for additional pressure relief . Assessment and plan: . Writer called and spoke to (R1's) healthcare power of attorney (HCPOA), her daughter (Name) to discuss radiographic findings . (daughters name) asked writer when the femur fracture may have occurred, unfortunately this is not something I am able to answer. It would take a high impact injury such as a fall to fracture a femur in this manner. (R1) did have a fall on 9/2/24 . (daughters name) decision to proceed with non-operative management [sic] .after discussion, there is limited splinting that is available for this, and positioning with pillows and limiting flexion would be appropriate. Wwriter spoke to (daughters name) as she was concerned about's [sic] splinting the femur.Orders: 1. Monitor knee for skin integrity. Keep knee stabilized with pillows. 2. may get up for meals . On 10/6/24 R1's 'Physician Monthly Progress,' states in part: routine visit .(R1) had already been diagnosed with closed fracture of the right tibia plateau but most recently after being evaluated by orthopedics and nurses staff [sic], had an x-ray on 10/4/24 that also shows left femur fracture. Non operative treatment decided by family and orthopedic team .she is lying in bed sleeping. no acute distress. she has her right knee in a brace. on her left knee, she has a bulge noted that has sticky cushioning material on it for protection .6. History of bilateral chronic knee pain. Continue morphine, recently increased to QID secondary to her right tibial plateau fracture and now left femur fracture . On 10/7/24, R1's Orthopedic NP note, written by NP C, states in part: .writer found 2 knee abduction pillows. The goal of splinting is to decrease the flexion that (R1) is able to do, however she has a permanent flexion contracture and her fracture is displaced, so standard splinting was not an option. I also had to take in consideration her potential for compromised skin integrity given her age and limited motion. The overall concern was that the displaced femur could break through the skin . Assessment and Plan: .report the application of the 2 soft abduction knee pillows to help reduce flexion of the knee. Writer discussed that the greatest concern is that the displaced femur fracture could break through the skin causing an open fracture which would prompt a hospital admission and IV (intravenous) antibiotics and possible surgical interventions. (daughters name) reported understanding .Foley catheter would be appropriate at this time to reduce rolling and movement for incontinence care.Orders: 1. Monitor knee for skin integrity. 2. Keep knee pillows (2) on at all times. May remove for skin checks or hygiene as needed. 3. monitor for signs of infection. 4. may get up for meals. 5. insert foley catheter. 6. call orthopedics department for any questions or concerns . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525114	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sauk CO Health Care Center	1051 Clark St Reedsburg, WI 53959

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 10/11/24 at 19:36 (7:36 PM), R1's Nurses note states in part: Skin problems: writer changed mepilex to L knee d/t (due to) soaked w/serosanguineous drainage. There is no evidence of an assessment, measurement of area, R1's provider or HCPOA was being updated regarding this note or change in R1's Left knee condition. R1 was sent to the hospital on 10/14/24 around 1:52 PM. On 10/14/24 at 2:53 PM, R1's Emergency Department note states in part: Today the skin over the distal end of the femur broke down and she now has an open wound over the fracture and concerning for open fracture . Musculoskeletal: Comments: Hands elbows and hips contractured, patient is in bilateral leg splints, open wound to left medial knee area with moderate serous drainage .Neurological: .nonverbal, moaning occasionally unrelated to cares. On 10/14/24 at 3:50 PM, R1's Orthopedic note states in part: .Reason for admission: impending open left distal femur fracture. History of present illness: .She had a progressive concerning appearance of her distal femur fracture site with tenting of the skin and now with an ulceration overlying the bony prominence and concern for impending open fracture of the distal femur . Plan: 1 .Activated medical power of attorney elected to proceed with a closed reduction procedure with splinting +/- any incision and drainage or irrigation and debridement determined to be necessary intraoperatively. She had no interest in amputation and no interest in any type of internal fixation of the distal femur fracture . On 10/14/24 at 3:47 PM, R1's Hospital Documentation indicates in part: Chief complaint leg injury. Presentation: Is unsure how the patient fell . On my encounter, patient is moderate distress .patient was hospitalized in the beginning of September for a fall .Reason for admission: Left femur fracture management. On 10/15/24 at 2:00 PM, R1's Hospital Documentation states in part: .scheduled for closed reduction and possibly debridement of open wound by orthopedic surgery this afternoon.Problems: Type I or Type II open comminuted intra-articular fracture of distal end of left femur . On 10/15/24 at 6:06 PM, R1's Hospital Documentation states in part: .Preoperative diagnoses: open, comminuted, displaced, left distal femur fracture. Postoperative diagnosis: Open, comminuted, displaced, left distal femur fracture. Procedure: 1. Open reduction of comminuted, displaced, left distal femur fracture. Application of left knee brace.3. irrigation and debridement/incision and drainage of open left distal femur fracture, debridement of skin, soft tissue and bone/femur. skin incision measures 5cm (centimeters). Open skin wound measured 1cm.Findings: .grade 1, open left distal femur fracture. fracture was significantly displaced, shortened and with valgus angulation. The distal medial femoral metaphysis was protruding through the skin medial with overlying ulceration and breakdown of skin. Debridement of open wound and ulceration of skin debridement of soft tissue and bone. Improved alignment of left distal femur fracture. Indications: there was significant valgus deformity of her fracture, however, and there was tenting and protrusion of her skin along the distal and medial aspect of her thigh. Eventually there was skin breakdown due to overlying ulceration and an open distal femur fracture. This opened and began draining within the last several days . (continued on next page)

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	525114	A. Building B. Wing	10/30/2024

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	(Of note, an open fracture is a break where the bone protrudes through the skin or when there's a wound that reaches down to the broken bone. These types of fractures are more complicated and serious to treat because of the increased damage to the surrounding tissue such as muscles, tendons, and ligaments and there is an increased risk of infection.) On 10/15/24 at 4:30 PM, Surveyor interviewed MD J (Medical Doctor) who is R1's primary physician. MD J indicated after incident on 9/2/24, R1's left leg was not imaged at the hospital or worked up. Surveyor asked MD J regarding how R1's femur fracture became angulated and displaced., MD J indicated if it occurred on 9/2 and went undetected it could happen by rolling her or from pressure to the area. MD J indicated they couldn't have prevented the displacement if they didn't know about it. On 10/16/24 at 9:17 AM, Surveyor spoke with Ortho NP C regarding R1. NP C indicated she had her first encounter with R1 on 9/2 when she was brought to the ER. NP C indicated R1 was seen for a tibial plateau fracture and placed in a knee immobilizer due to permanent flexor contracture, her knees are always bent and R1 has severe knee arthritis. NP C indicated R1 had extensive imaging but no imaging of the left leg due to no injury visible to that leg. NP C indicated she didn't notice anything with R1's left leg. NP C indicated on 10/4 she was notified of a bump on R1's knee and R1 got x-rays which noted a 100% displaced femur fracture. NP C indicated R1's femur was completely separated. NP C indicated that DON B called her regarding R1's skin had broken open and possible open fracture. NP C indicated an open fracture is a life-threatening thing. NP C indicated upon R1's arrival the skin was broken and actively draining serous drainage, sharp fracture, R1 had the thinnest piece of tissue over the femur, a small piece of the distal femur was able to be reduced enough to get a flexion knee immobilizer on her, which she'll have for the rest of her life. NP C was unable to tell R1's daughter if the fracture did occur from 9/2 as no imaging was done and to break a femur and displace it, it takes a high energy impact to do that. The failure to prevent accidents from occurring due to CNA D and CNA E not safely transferring/ensuring R1 was in a safe position prior to trying to remove her incontinent brief resulted in a right tib/fib fracture and a left angulated and displaced femur fracture after a fall in the shower room as well as staff not following the fall procedure by lifting R1 off the floor without a nursing assessment created a reasonable likelihood for serious harm, thus leading to a finding of Immediate Jeopardy. The facility removed the jeopardy on 10/16/24 when it had completed the following: DON and ADON did a complete facility wide audit on transfer status of all residents to confirm accuracy on the care card. Resident care plans were reviewed for transfer status and ensured accuracy. All staff received immediate education prior to their next working shift on the following: Transfers: * Reviewed transfer policy and procedure and will present to all staff. * Always follow care card on how to transfer resident * Always use a gait belt when transferring resident (continued on next page)

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	525114	A. Building B. Wing	10/30/2024

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	* Always use 2 people for Hoyer transfer * Do not bump arms/legs during transfer * Do not attempt to remove garments resident is sitting on or pull -on the garments a resident is sitting on. Take time to ensure resident is ready for transfer into shower chair, all articles of clothing are off. If not, use safe transfer method to stand up or lay resident down. * Always report to nurse if resident is not tolerating current transfer method. Falls: * Reviewed facility fall policy and procedure and will present to all staff. * If resident falls, activate emergency cord and if no response, call out. * DO NOT move resident until an RN assesses for injury * RN to complete fall assessment including neurological and body assessment with vitals * If injury, update MD and call 911 to send to hospital for evaluation if ordered * Update: POA, DON/ADON, Administrator Skin: * Reviewed COC policy and procedure and will discuss will all nursing staff on recognition of COC and MD Notification. * CNA's report any and all skin changes to your nurse immediately * Nurse assess skin and document with measurements * Update DON and Wound Nurse * Update MD and POA Audits will be completed on all of the above items. Findings will be presented at least quarterly at QAPI. * Beginning on 10/16/24 the facility will begin auditing resident transfers as follows: 5x weekly x 4 weeks; weekly x 4 weeks; monthly x 1 month. * All falls will be audited for the following: Root Cause identification MD Notification; POA/Family Notification, if applicable, Care Plan updated, RN Assessment done 5x weekly x 4 weeks; weekly x 4 weeks; monthly x 1 month.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33166 Based on interview and record review, the facility did not ensure that each resident's drug regimen was adequately monitored and that the drug regimen was free from adverse consequences for 1 of 1 resident (R2) reviewed for adequate monitoring. R2 has a diagnosis of Atrial Fibrillation (an irregular heartbeat, that occurs when the upper chambers of the heart beat rapidly and irregularly) and receives Coumadin (a blood thinner). R2 was prescribed Bactrim on 10/1/24. Antibiotics can potentiate the effect of Warfarin (Coumadin). The facility did not complete monitoring for symptoms of drug interactions. R2 was sent to the hospital after a fall and was found to have a supratherapeutic (high) INR (international normalized ratio, a lab that measures how long it takes the blood to clot) of 4.5. The therapeutic range for INR is 2-3. This is evidenced by: The facility's policy titled Warfarin (Coumadin) Monitoring states in part; Purpose: To assure resident safety with a goal to maintain INR and keeping within residents therapeutic range. No adverse side effects from Coumadin. Policy: All residents receiving Warfarin therapy will also receive monitoring of its efficacy via resident observation and PT/INR (Prothrombin Time/International Normalized Ratio), A lab the [sic] measures clotting time, monitoring per physician order monitoring throughout the course of co-treatment. 11. The nurse will add the resident to the 24-hour report and indicate that co-treatment is taking place. This will communicate the need for additional monitoring of symptoms of active bleeding. 13. The nurse supervisor will provide ongoing monitoring of the implementation of this policy, including appropriate observation action, and documentation. According to http://packageinserts.bms.com/pi/pi_coumadin.pdf, Concomitant use of drugs that increase bleeding risk, antibiotics, antifungals, botanical (herbal) products. More frequent INR monitoring should be performed when starting or stopping other drugs, including botanicals, or when changing dosages of other drugs, including drugs intended for short-term use (e.g., antibiotics, antifungals, corticosteroids.) R2 was admitted to the facility on [DATE]. R2 has diagnoses of atrial fibrillation, dementia, Chronic Kidney Disease, and Diabetes. R2's care plan dated 5/21/24 states in part: resident will remain within individualized target range for INR without side effect. No uncontrolled bleed, minimal bruising. R2's physician's orders for September state in part: Coumadin 6 mg (milligrams) add to 1 mg total dose 7 mg daily order date 10/16/23. R2's Injury/Incident/Accident Investigation Report dated 9/30/24 states in part; resident slid off the edge of his bed onto the floor on his buttocks. ROM (Range of Motion) per baseline. Denies hitting head. No bruising or redness noted. Fix it to prevent further recurrence: UA obtained. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	It should be noted R2 had no symptoms of a Urinary Tract Infection (UTI). R2's nursing notes state the following: On 9/30/24 at 15:27 (3:27 PM) late entry for 9/29/24, resident continues to wander during shift. Refused straight cath (a tube inserted into the bladder to drain urine) refused personal cares and toileting/changes. N. O. (New order) obtained for UA/C&S (Urinalysis with Culture and Sensitivity), a test to check for urinary tract infection, what bacteria is present and appropriate antibiotic to use. Specimen obtained after attempts to straight cath. UA positive for UTI, culture pending. On 9/30/24 at 3:58 AM states in part: new lab: UA with culture and sensitivity if indicated. Increased confusion, increased sediment and mucous as well as very dark urine when the nursing staff cathed (Catheterization-tube inserted into bladder.) Of note confusion, increased sediment, mucous and dark urine are not criteria to gather a UA. On 10/1/24 at 9:19 AM, new orders received and noted: Bactrim DS (double strength) take 1 tablet PO (by mouth) BID (twice a day) for potential UTI. MD educated on protocol per facility that normally we wait for the culture to return before obtaining antibiotics. On 10/1/24, physician order Bactrim DS take 1 tablet PO BID x 7 days for potential UTI. MD educated on protocol per facility that normally we wait for the culture to return before obtaining antibiotics. Of note, there is no indication that the facility made the physician aware R2 was receiving Coumadin. Bactrim is a medication known to potentiate Coumadin. On 10/3/24 at 19:52 (7:52 PM), Urinary findings continues to be treated with Bactrim DS. On 10/4/24 at 23:02 (11:02 PM), Urinary findings continues to be treated with Bactrim DS. Of note, there is no indication in R2's medical record indicating the facility notified the anticoagulation clinic R2 was started on Bactrim. On 10/6/24 22:02 (10:22 PM), A telephone order states send to (Hospital Name) for evaluation of possible fracture or displacement. A hospital laboratory report dated 10/6/24 states Protime (lab used to see how long it takes the blood to clot) 42.1 (high) normal range 11.5-14.5. INR 4.5 (high) normal range 2-3. INR supratherapeutic (critically high). Nursing note on 10/7/24 at 9:05 AM states returned from emergency room . Nursing note on 10/7/24 at 10:57 AM states in part: new orders received and noted. Discontinue Bactrim Start Keflex 500 mg TID (Three Times a Day) (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Hold amlodipine and Dyazide times 3 days. (Blood Pressure Medications) Hold Coumadin today. Start Coumadin 4mg on 10/8/24 and 10/9/24. INR lab on 10/10/24. On 10/16/24 at 5:00 PM, Surveyor interviewed DON B (Director of Nursing) regarding R2's medication monitoring. DON B stated when R2 was placed on the Bactrim the facility should have contacted the anticoagulant clinic and typically we check the INR in 1-3 days after antibiotic is started. Surveyor asked DON B if that occurred for R2, and DON B stated, I cannot see we followed through with this process and 100 percent we should have. R2 was receiving Coumadin 7 mg daily. R2 was started on Bactrim DS which potentiates Coumadin. The facility did not monitor R2's INR while R2 was receiving Bactrim. R2's INR was critically high at 4.5 placing R2 at increased risk for bleeding.