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	02/03/2026

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 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** Based on interview and record review, the facility did not ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, are reported immediately to the administrator of the facility and to other officials, including the State Survey Agency, in accordance with State law through established procedures for 1 of 3 residents (R2) reviewed for abuse.Facility became aware of an injury of unknown origin on 12/19/25 when R2 was sent to the emergency department and was found to have a closed nondisplaced fracture of the left pinky finger. The facility failed to report it to the state within the required timeframe.Evidenced by:The facility policy entitled Reporting and Investigation of Alleged Caregiver Misconduct or Resident Rights Violation, dated 12/2025, states, in part: . Policy: It is the policy of the Sauk County Health Care Center that each resident will be free from Abuse. Sauk County Health Care Center will take all reasonable measures to ensure resident safety and security and will promptly investigate all reports/allegations of resident rights violations, abuse, neglect, mistreatment, injuries of unknown source or misappropriation of property, resident to resident incidents, reporting the investigative results to the appropriate agencies in accordance with state and federal laws.Definitions of Abuse and Neglect: .g. Injuries of Unknown Origin: An injury should be classified as an injury of unknown source when both of the following conditions are met:i. The source of the injury was not observed by any person or the source of the injury could not be explained by the resident;ii. The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time.PROCEDURE: RESPONDING/INVESTIGATING/PROTECTION:All allegations of misconduct will be thoroughly investigated.3. Any facility employee having either direct or indirect knowledge of potential misconduct involving a facility resident shall immediately follow the reporting procedures.4. The Supervisor receiving verbal or written information shall take prompt measures to assess and ensure the safety and welfare of the resident(s) involved, immediately notify the Administrator or Administrator designee of the allegation along with any other appropriate individuals. Following notification of the Administrator, the supervisor/administrator reporting will immediately complete the Alleged Nursing Home Resident Mistreatment Report via the online reporting system.5. The supervisor or designee will report suspected crimes to law enforcement. Serious injuries will be reported no later than 2 hours after discovery. Nonserious injuries will be reported no later than 24 hours after discovery.8. For the Nursing Home, the Administrator, Social Worker, DON (Director of Nursing) or designee will complete the investigation.R2 was admitted to the facility on [DATE] and has diagnoses that include cerebrovascular disease (a group of conditions that impair brain blow flow, including stroke, carotid stenosis (narrowing of the carotid arteries in the neck caused by plaque buildup), aneurysms (dangerous bulge in the artery wall caused by weakened vessels, which can cause severe bleeding or death if ruptures) (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525114	A. Building B. Wing	02/03/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and vascular malformations. These occur when blood vessels in the brain are damaged or blocked by atherosclerosis (condition where plaque builds up inside your arteries and overtime hardens and causes your arteries to narrow), blood clots, or rupture and unspecified dementia, severe with anxiety, and bilateral osteoarthritis of hip.R2's Minimum Data Set (MDS) Significant Change Assessment, dated 1/22/26, shows R2 has severe cognitive impairment with a BIMS (Brief Interview of Mental Status) score of 00.R2's Progress Notes as follows:12/19/25, at 2:55 PM, Skin Problems: Left pinky cleaned as ordered, notified Charge nurse of change in wound appearance.12/19/25, 5:35 PM, General Skin Condition: Resident left pinky finger noted to have a large hematoma- on lateral finger red and warm- . POA (power of attorney) and on call doctor phoned and he would like to have this hematoma looked [sic] in ER (emergency room) .12/19/25, at 5:45 PM, Resident Transferred: 12/19/25 Time of Transfer: 6:00 PMTransferred to: [Reedsburg Area Medical Center] . by ambulance.12/19/25, 11:39 PM, Returned from: Emergency Room. Return Date: 12/19/25. Return Time: 10:33 PM. R2's Hospital Rapid Assessment and Management, dated 12/19/25, at 6:32 PM, states, in part: . Brief HPI (history of present illness): .Patient presents with: Hand Pain. Sent from the Sauk County Care Center due to swollen left pinky, with pus drainage. Unclear if there was an associated injury. R2's hospital Discharge summary, dated [DATE], states, in part: . Chief Complaint: Hand pain.Medical Decision Making:R2 here with hand pain. X-ray imaging with possible nondisplaced fracture involving the mid diaphysis of the pinky finger distal phalanx.XR Hand Min 3 Views L (left) (Final Result): Impression: 1. Possible nondisplaced fracture involving the med diaphysis of the pinky finger distal phalanx.Indication: left pinky hematoma/abscess, eval for fracture.Findings: Bones appear osteopenic. Possible nondisplaced fracture involving the mid diaphysis of the pinky finger distal phalanx best seen on the oblique view.Diagnosis: ImpressionAbscessClosed Nondisplaced fracture of distal phalanx of left little finger.On 2/3/26 at 10:54 AM, Surveyor interviewed LPN E (Licensed Practical Nurse) and asked if she could tell Surveyor about R2's left pinky finger. LPN E indicated it had been broken about a month ago. LPN E indicated R2's left pinky had been tested, and osteomyelitis was found at that time. LPN E indicated R2's left hand is pretty contracted, and staff have to pull R2's fingers up to get the palm protectors on. LPN E indicated she is not aware of how R2's left pinky finger had been broken. On 2/3/26 at 11:30 AM, Surveyor requested from DON B (Director of Nursing) an incident report for R2's wound from 12/10/25 and weekly wound assessment documentation. DON B came back and informed Surveyor there was no incident report for R2 and there is no weekly wound assessment documentation.On 2/3/26 at 4:34 PM, Surveyor interviewed NHA A (Nursing Home Administrator) and asked if an injury of unknown source should be reported to the state. NHA A indicated yes. Surveyor asked NHA A regarding R2. Surveyor asked NHA A if R2's fracture should have been reported to state with not knowing what the cause was, NHA A indicated yes. Surveyor asked NHA A if R2's closed nondisplaced fracture to the left pinky finger should have been investigated to determine the cause. NHA A indicated yes.

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	02/03/2026

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that in response to allegations of abuse, neglect, exploitation, or mistreatment, that all alleged violations are thoroughly investigated, and that steps were taken to prevent further abuse for 1 of 3 Residents reviewed (R2).Facility became aware of an injury of unknown origin on 12/19/25 when R2 was sent to the emergency department and was found to have a closed nondisplaced fracture of the left pinky finger. The facility failed to conduct and complete a thorough investigation.Evidenced by:The facility policy entitled Reporting and Investigation of Alleged Caregiver Misconduct or Resident Rights Violation, dated 12/2025, states, in part: . Policy: It is the policy of the Sauk County Health Care Center that each resident will be free from Abuse. Sauk County Health Care Center will take all reasonable measures to ensure resident safety and security and will promptly investigate all reports/allegations of resident rights violations, abuse, neglect, mistreatment, injuries of unknown source or misappropriation of property, resident to resident incidents, reporting the investigative results to the appropriate agencies in accordance with state and federal laws.Definitions of Abuse and Neglect: .g. Injuries of Unknown Origin: An injury should be classified as an injury of unknown source when both of the following conditions are met:i. The source of the injury was not observed by any person or the source of the injury could not be explained by the resident;ii. The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time.PROCEDURE: RESPONDING/INVESTIGATING/PROTECTION:All allegations of misconduct will be thoroughly investigated.3. Any facility employee having either direct or indirect knowledge of potential misconduct involving a facility resident shall immediately follow the reporting procedures.4. The Supervisor receiving verbal or written information shall take prompt measures to assess and ensure the safety and welfare of the resident(s) involved, immediately notify the Administrator or Administrator designee of the allegation along with any other appropriate individuals. Following notification of the Administrator, the supervisor/administrator reporting will immediately complete the Alleged Nursing Home Resident Mistreatment Report via the online reporting system.5. The supervisor or designee will report suspected crimes to law enforcement. Serious injuries will be reported no later than 2 hours after discovery. Nonserious injuries will be reported no later than 24 hours after discovery.8. For the Nursing Home, the Administrator, Social Worker, DON (Director of Nursing) or designee will complete the investigation. THOROUGH INVESTIGATION:All nursing homes must immediately begin a thorough investigation of any reported incident, collect information that corroborates or disproves the incident, and document the findings for each incident. A thorough investigation may include: .-Identifying and interviewing other staff or residents in the immediate area at the time of the incident who may have witnessed what occurred.-Interviewing other residents to determine if they have been abused or mistreated.-Interviewing staff who worked previous shifts to determine if they were aware of an injury or incident.13. The investigation will be conducted within 5 working days of the alleged incident.14. The Administrator. shall complete. Caregiver Misconduct Incident Report. The completed form, along with a copy of the Alleged form and the appropriate supporting documentation will be submitted via the MISCONDUCT INCIDENT REPORTING SYSTEM and/or forwarded to the Division of Quality Assurance, Office of Caregiver Quality. This will be completed within five working days of the alleged incident. R2 was admitted to the facility on [DATE] and has diagnoses that include cerebrovascular disease (a group of conditions that impair brain blow flow, including stroke, carotid stenosis (narrowing of the carotid arteries in the neck caused by plaque buildup), aneurysms (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	02/03/2026

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(dangerous bulge in the artery wall caused by weakened vessels, which can cause severe bleeding or death if ruptures) and vascular malformations. These occur when blood vessels in the brain are damaged or blocked by atherosclerosis (condition where plaque builds up inside your arteries and overtime hardens and causes your arteries to narrow), blood clots, or rupture and unspecified dementia, severe with anxiety, and bilateral osteoarthritis of hip.R2's Minimum Data Set (MDS) Significant Change Assessment, dated 1/22/26, shows R2 has severe cognitive impairment with a Brief Interview of Mental Status (BIMS) score of 00.R2's Progress Notes as follows:12/19/25, at 2:55 PM, Skin Problems: Left pinky cleaned as ordered, notified Charge nurse of change in wound appearance.12/19/25, 5:35 PM, General Skin Condition: Resident left pinky finger noted to have a large hematoma- on lateral finger red and warm- . POA (power of attorney) and on call doctor phoned and he would like to have this hematoma looked [sic] in ER (emergency room) .12/19/25, at 5:45 PM, Resident Transferred: 12/19/25 Time of Transfer: 6:00PMTransferred to: [Reedsburg Area Medical Center] . by ambulance.12/19/25, 11:39 PM, Returned from: Emergency Room. Return Date: 12/19/25. Return Time: 10:33 PM. R2's Hospital Rapid Assessment and Management, dated 12/19/25, at 6:32 PM, states, in part: . Brief HPI (history of present illness): .Patient presents with: Hand Pain. Sent from the Sauk County Care Center due to swollen left pinky, with pus drainage. Unclear if there was an associated injury. R2's hospital Discharge summary, dated [DATE], states, in part: . Chief Complaint: Hand pain.Medical Decision Making:R2 here with hand pain. X-ray imaging with possible nondisplaced fracture involving the mid diaphysis of the pinky finger distal phalanx.XR Hand Min 3 Views L (left) (Final Result): Impression: 1. Possible nondisplaced fracture involving the med diaphysis of the pinky finger distal phalanx.Indication: left pinky hematoma/abscess, eval for fracture.Findings: Bones appear osteopenic. Possible nondisplaced fracture involving the mid diaphysis of the pinky finger distal phalanx best seen on the oblique view.Diagnosis: ImpressionAbscessClosed Nondisplaced fracture of distal phalanx of left little finger.On 2/3/26 at 10:54 AM, Surveyor interviewed LPN E (Licensed Practical Nurse) and asked if she could tell Surveyor about R2's left pinky finger. LPN E indicated it had been broken about a month ago. LPN E indicated R2's left pinky had been tested, and osteomyelitis was found at that time. LPN E indicated R2's left hand is pretty contracted, and staff have to pull R2's fingers up to get the palm protectors on. LPN E indicated she is not aware of how R2's left pinky finger had been broken. Surveyor asked LPN E what the facility's process is when a wound or a change of condition is observed with a resident. LPN E indicated the floor nurse would report it to the nurse supervisor. The nurse supervisor would do an incident report, report to the physician and receive an order.On 2/3/26 at 11:30 AM, Surveyor requested from DON B (Director of Nursing) an incident report for R2's wound from 12/10/25 and weekly wound assessment documentation. DON B came back and informed Surveyor there was no incident report for R2 and there is no weekly wound assessment documentation.On 2/3/26 at 4:34 PM, Surveyor interviewed NHA A (Nursing Home Administrator) and asked if an injury of unknown source should be reported to the state. NHA A indicated yes. Surveyor asked NHA A if R2's closed nondisplaced fracture to the left pinky finger should have been investigated to determine the cause of the fracture, NHA A indicated yes.

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	02/03/2026

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 - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure that residents received treatment and care in accordance with professional standards of practice (N6, Wisconsin Nurse Practice Act) for 1 of 3 sampled residents (R2).On 12/10/25 staff observed and documented an open area on R2's left 5th digit. The facility did not complete an initial comprehensive assessment of the wound including, measurements, size and characteristics. On 12/19/25, R2 was sent to emergency department due to deterioration in the wound. R2 was diagnosed with a displaced fracture and osteomyelitis requiring antibiotic therapy. Evidenced by:According to the Wisconsin Nurse Practice Act, N6.03(1), An R.N. (Registered Nurse) 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 (Licensed Practical Nurse) or less skilled assistants.(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.Per the wound care education institute Best Practices for Wound Assessment and Documentation states, in part: . Foundational elements of wound assessment. A structured approach to wound assessment is key to capturing the clinical picture and determining the best course of action for care. Here are the essential components to document: .1. Precise anatomical location.2. Wound classification and etiology. Determine and document the wound's origin. Common types include: Pressure injuries: Classify by stage using the National Pressure Injury Advisory Panel's (NPIAP) guidelines. Arterial or venous ulcers: Note underlying circulatory insufficiencies. Diabetic foot ulcers: These are often neuropathic, so assess the patient's offloading status. The patient should be assigned a [NAME] grade and updated as needed. Surgical incisions or traumatic wounds: Include the mechanism of injury or surgical intent.Documenting wound etiology ensures targeted interventions and appropriate resource use .3. Accurate wound measurements.*Length.*Width.*Depth.4. Wound bed characteristics Quantify the percentage and type of tissue present: Granulation: Red, moist, and bumpy - This is a sign of healthy tissue growth. Slough: Yellow/white, stringy, or moist. May be adherent or loosely attached. This is non-viable and may require debridement. Eschar: Thick, dry, black, or brown. Document if stable or if debridement is needed. Hyper granulation: Assess for signs of infection and/or necessary treatment changes, such as stopping a collagen application.Descriptive wound bed assessments help monitor healing phases and guide appropriate debridement strategies.5. Wound edge and margin assessment Evaluate wound edges for signs of healing or chronicity: Defined vs. undefined: Defined edges are more acute, and undefined may suggest chronicity. Epibole (rolled edges): This is common in stalled wounds. Undermining or maceration: This may indicate moisture imbalance or shearing/friction forces.Marginal changes can be early indicators of delayed healing or infection.6. Exudate characteristics Drainage quality provides vital clues about wound status: Amount: None, scant, light, moderate, or heavy. Type: Serous (clear), serosanguineous, sanguineous, seropurulent, or purulent. Color and consistency: Thick yellow/green with odor may indicate infection. Odor: Describe only after cleansing to eliminate confounding factors.Always (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	02/03/2026

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 - Actual harm Residents Affected - Few	correlate exudate changes with wound progression and signs of infection.7. Peri wound skin statusDocument any abnormal findings in the tissue surrounding the wound: Color: Erythema may signal infection or inflammation. Texture: Watch for induration, bogginess, or dryness. Breakdown: Maceration, excoriation, or denuded skin may indicate excessive moisture or friction.Healthy peri wound skin supports optimal wound healing and should be protected as part of the overall care plan.8. Pain and symptom reportingPain is a critical, yet often under-documented, aspect of wound assessment. Capture: Intensity: Use a numeric or verbal pain scale. Descriptors: Burning, aching, stabbing, etc. Timing: Before, during, or after dressing changes. Management: Note what interventions alleviate or exacerbate pain The facility's policy entitled Wound Treatment Management, dated 4/2024, states, in part: . Policy: To promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders.Policy Explanation and Compliance Guidelines: .8. The effectiveness of treatments will be monitored through ongoing assessment of the wound. Considerations for needed modifications include: a. Lack of progression towards healing. b. Changes in the characteristics of the wound.R2 was admitted to the facility on [DATE] and has diagnoses that include cerebrovascular disease (a group of conditions that impair brain blow flow), unspecified dementia, severe with anxiety, and bilateral osteoarthritis of hip.R2's Minimum Data Set (MDS) Significant Change Assessment, dated 1/22/26, shows R2 has severe cognitive impairment with a Brief Interview of Mental Status (BIMS) score of 00.R2's progress notes are as follows: R2's Progress Note, dated 12/10/25, at 12:34 PM, states: Left hand pinky has open area reported to supervisor.Important to note: There is no wound assessment with characteristics of wound or measurements indicated when found.R2's Progress Note dated 12/11/25, at 3:12 PM, states: Orders Received from [physician name] .Cleanse scab on pinky finger on left hand with soap and water-apply betadine and allow to dry then leave open to air. R2's Care Plan states, in part: . Problem: Potential for tissue integrity impairment. Related to: Immobility, HLD (hyperlipidemia), CAD (coronary artery disease), Dry, scaling areas, advanced age, fragile skin, incontinence. Manifested by: Reddened areas, itching, edema, moist areas, blisters, bruises easily.Goal: Skin will remain intact, Free of irritation, No breakdown of area. Goal Time: 2/26Approach: Nurses- Inspect skin especially bony prominences and dependent areas for redness/breakdown daily. Assess skin status.R2's Progress notes continued: 12/11/25, at 3:12 PM, Skin Problems: Wound care to left pinky as ordered .12/12/25, at 1:49 PM, Procedure Done: wound treatment done per order.12/13/25, at 12:24 AM, Procedure Done: Wound treatment done per order.12/13/25, at 12:35 PM, Procedure Done: wound treatment done per order.12/14/25, at 12:16 AM, Procedure Done: wound treatment done per order.12/15/25, at 2:49 PM, Weekly Skin Assessment: within normal limits, warm, dry, no open areas. Skin Problems: small wound to left pinky, being treated. Foot Problem/Care: Nails are clean and smooth; heels are firm and blanchable.Important to note this is not a thorough wound assessment. This does not indicate characteristics of the wound or measurements. There is no documentation of wound assessments from 12/10/25 to current to indicate staff are monitoring R2's wound for decline or improvement.12/15/25, 16:43 PM, Wound treatment done per order to left pinky finger, left pinky nail appears to be falling off, no s/s (signs or symptoms) of infection.Important to note: This is a change in the wound. There is no physician notification or a thorough assessment of the wound documented in R2's record.12/16/25 at 12:59 PM, Skin Problems: Wound care to left pinky as ordered.12/17/25 at 12:26 PM, Skin Problems: Wound care to left pinky as ordered.12/18/25 at 12:43 PM, Procedure Done: wound treatment done per order.12/19/25 at 2:55 PM, Skin Problems Left pinky cleaned as ordered, notified Charge nurse of change in wound appearance.12/19/25 5:35 PM, General Skin Condition: Resident left pinky finger noted to have a large (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	02/03/2026

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 - Actual harm Residents Affected - Few	hematoma- on lateral finger red and warm- . POA (power of attorney) and on call doctor phoned and he would like to have this hematoma looked [sic] in ER (emergency room) .Important to note: There are still no wound characteristics/assessments documented in R2's record.12/19/25 at 5:45 PM, Resident Transferred: 12/19/25 Time of Transfer: 6:00 PMTransferred to: [Hospital name] . by ambulance. R2's Rapid Assessment and Management, dated 12/19/25, at 6:32 PM, states, in part: . Brief HPI (history of present illness): .Patient presents with: Hand Pain. Sent from the [Nursing Home name] due to swollen left pinky, with pus drainage. Unclear if there was an associated injury. Patient nonverbal at baseline.Focused Physical Exam: Patient is holding her hand gripped aggressively. Left pinky is quite swollen on the ulnar aspect, purplish, with purulent drainage. (of note: R2's record does not have any documentation of purulent drainage being present prior.)R2's hospital Discharge summary, dated [DATE], states, in part: . Chief Complaint: Hand painHistory of Present Illness: R2 presents with hand pain. History provided by daughter in law at bedside. Per daughter in law, wound with blood blister to left pinky was noticed about 1 week ago. Yesterday, noticed worsening swelling and redness and drainage prompting sending the patient to the emergency department today. Patient is nonverbal and non-ambulatory at baseline. No known injuries. Mental status is at baseline. Goals of care primarily end-of-life and comfort oriented.Orders Placed at this Encounter:- Wound culture with gram stain.- XR (x-ray) Hand Min 3 Views .- Ambulatory Referral to Orthopedic Surgery.-Cephalexin 500 mg (milligrams) Oral Capsule.1 capsule by mouth 2 times daily for 7 days.-Sulfamethoxazole-Trimethoprim 800-160 mg oral tablet. Take 1 tablet by mouth 2 times daily for 7 days.Physical Exam: .Skin: General: Skin is warm and dry. Comments: Left hand 2+ radial pulse, approximately 4 cm (centimeters) hematoma with purulent drainage to ulnar aspect of fifth digit, finger contracted at baseline.Medical Decision Making:R2 here with hand pain.Concern for hematoma to the lateral aspect of her hand that is now infected with purulent drainage. I am concerned for underlying infection. I had an extensive discussion with family member at bedside. We discussed likelihood of infection and possibility of worsening without surgical intervention, osteomyelitis, abscess, fracture. Would require evaluation by hand surgeon and consideration for procedure. X-ray imaging with possible nondisplaced fracture involving the mid diaphysis of the pinky finger distal phalanx. Finger not amenable to buddy taping due to her significant contractures. Family relate that goals of care currently end-of-life and comfort. Would not want to pursue any surgical evaluation or intervention. They are amenable (open to) to drainage in the emergency department with oral antibiotics. I &D (incision & drain) was performed. Wound culture obtained. Provided with a dose of Bactrim and Keflex. They were provided a referral to hand clinic for wound re-evaluation if they so choose. Option to follow up with hand clinic or primary care doctor.XR Hand Min 3 Views L (left) (Final Result): Impression: 1. Possible nondisplaced fracture involving the med diaphysis (central shaft of a long bone) of the pinky finger distal phalanx (bone found at the tip of finger) .Indication: left pinky hematoma/abscess, eval for fracture.Findings: Bones appear osteopenic. Possible nondisplaced fracture involving the mid diaphysis of the pinky finger distal phalanx best seen on the oblique view.Diagnosis: ImpressionAbscessClosed Nondisplaced fracture of distal phalanx of left little finger. R2's After Visit Summary, dated 12/19/25, states, in part: . Reason for visit: hand pain.Diagnoses: Abscess. Closed nondisplaced fracture of distal phalanx of left little finger.Lab Tests in Progress: Wound Culture with gram stainImaging Tests: XR Hand Min 3 Views L.Orders: 1) Cephalexin 500 mg 1 capsule by mouth 2 times daily for 7 days. 2) Sulfamethoxazole-trimethoprim 800-160 mg 1 tablet by mouth 2 times daily for 7 days. 12/19/25 11:39 PM, Returned from: Emergency Room. Return Date: 12/19/25. Return Time: 10:33 PM.12/19/25, at 11:39 PM, Orders received from [Physician name] Result: . 1) Cephalexin (first generation antibiotic used to treat (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	02/03/2026

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 - Actual harm Residents Affected - Few	various bacterial infections) 500 mg (milligrams) by mouth 2 times daily for 7 days abscess to left little finger 2) Sulfamethoxazole-trimethoprim (antibiotic also used to treat various bacterial infections) 800-160 by mouth 2 ties daily for 7 days abscess to left little finger. Of note: facility did not assess R2's abscess upon returning from the hospital or document the size or characteristics for this area. 12/20/25 at 11:34 PM, Orders received from [Physician name} Result: . 1) Follow-up with hand clinic for wound re-evaluation. If you would prefer to not see a specialist given goals of care, please follow-up with PCP (Primary Care Physician) . R2's Wound Culture Results, dated 12/26/25, states, in part: . Specimen Description: Wound Special Requests: Hand, Left Gram Stain: No Epithelial Cells Seen. WBCS (white blood cells) few. Gram Positive COCCI rare. Culture Results: Moderate growth of Staphylococcus Aureus Susceptibility. R2's Nurse Practitioner (NP) Progress Note, dated 12/28/25, states, in part: . Routine Visit: 12/28/25. S (situation): . New concerns with patient are her left-hand wound. Noted for the month of December. December 11th patient was found to have a scab on her pinky finger for her left hand. She was taken to the ER on [DATE]. This was secondary to hematoma that was noted on the left 5th digit. New orders were received after wound culture grew staph infection.Patient is placed on Keflex and Bactrim at this time. Left fifth digit tip is blackened. At this time unable to assess fully as extension is not complete. Area had foul odor with moisture noted in the [NAME] surface of hand. Unable/difficult to assess secondary to the contractures and inability to open and extension complete. folded hand washcloth was placed wound was left open to air. Recommend follow-up with PCP (Primary Care Physician) and Hand Specialist.New orders will be to change dressing/washcloth to left hand as needed recommending frequent changes. Of note: there is no evidence of R2's abscess being monitored or assessed by facility staff from 12/19/25 to 12/29/25.NP D Progress Note, dated 12/29/25, states, in part: . Chief Complaint: Left little finger swelling. History of Present Illness: Writer was asked to consult and exam R2. Prior to evaluation, radiographs were reviewed with orthopedic surgeon [Physician name] and per the x-ray there is erosive bone loss at the 5th distal phalanx consistent with osteomyelitis. R2 was evaluated in the emergency room on [DATE].Physical Examination: .Hand/Upper Extremity Examination: Skin: Black eschar to the left little finger, distal phalanx. Fingernail is starting to fall off. Palpation/Tenderness: Tenderness to 5th distal phalanx with palpation. Upper extremity range of motion: Severe flexion contractures of all fingers of the left hand.Diagnostic Studies: Radiographs of the left hand were obtained 12/19/25 and per orthopedic team review of images demonstrate.Bone erosion of the 5th distal phalanx consistent with osteomyelitis.Plan: 1. Writer called and spoke to family member. and discussed treatment options including conservative measures such as monitoring, oral antibiotics, and repeat x-rays versus surgical removal of the finger, however, it would not be our recommendation to proceed with surgery due to R2's current health state and physical condition. The surgery would require general anesthesia and her to be intubated (we would need to use a paralytic to be able to access her hand for surgery given her contractures.) .3) Monitor hand and finger daily, applying betadine.4) Monitor for systemic signs of infection such as redness, swelling, increased pain, drainage, red streaking, and fever.5) Prescribed daily antibiotic therapy for 6 weeks (which may extend), to include Bactrim 800/160 mg twice daily) .6) Follow up x-rays in 4 weeks of the left hand, little finger. R2's Physician Orders, dated 1/19/25, states, in part: . Monitor left hand pinky for systemic infection- increase warmth, red streaking, fever/rapid heartbeat/increase in pain or discomfort every shift AM PM NOC First Date: 12/30/25.Important to note: there is no documentation of monitoring/assessment of R2's wound to left pinky finger until ordered by NP D on 12/30/25.On 2/3/26 at 10:54 AM, Surveyor interviewed LPN E (Licensed Practical Nurse) regarding R2's left fifth digit. LPN E indicated it had been broken about a (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	02/03/2026

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 - Actual harm Residents Affected - Few	month ago. LPN E indicated R2's left pinky had been tested, and osteomyelitis was found at that time. LPN E indicated R2's left hand is pretty contracted, and staff have to pull R2's fingers up to get the palm protectors on. LPN E indicated she is not aware of how R2's left pinky finger had been broken. Surveyor asked LPN E what the facility's process is when a wound or a change of condition is observed with a resident. LPN E indicated the floor nurse would report it to the nurse supervisor. The nurse supervisor would do an incident report, report to the physician and receive an order.On 2/3/26 at 11:30 AM, Surveyor requested from DON B (Director of Nursing) an incident report for R2's wound from 12/10/25 and weekly wound assessment documentation. DON B informed Surveyor there was no incident report for R2 and there is no weekly wound assessment documentation.On 2/3/26 at 11:56 AM, Surveyor left a message for R2's POA. Surveyor did not receive a phone call back.On 2/3/26 at 12:31 PM, Surveyor interviewed LPN F. Surveyor asked LPN F if she was the nurse that discovered the wound to R2's left pinky finger on 12/10/25. LPN F indicated yes, a CNA (Certified Nursing Assistant) reported to LPN F R2's left pinky finger was bleeding. LPN F indicated she had called the nurse supervisor, and LPN F and the nurse supervisor assessed R2's left pinky. LPN F indicated they cleaned the area and found a tiny [NAME] at the tip of R2's left pinky finger bleeding. LPN F indicated it was close to R2's fingernail. LPN F indicated the nurse supervisor then called the doctor. Surveyor asked LPN F to explain the facility process when a wound is found or a resident has a change of condition. LPN F indicated the floor nurse reports it to the nurse supervisor and the nurse supervisor calls the physician and completes the documentation on the wound or change of condition. Surveyor asked LPN F if she was aware of what caused the wound to R2's left pinky finger LPN F indicated she did not know.Surveyor attempted to phone R2's PCP and left a message on 2/3/26 at 1:13PM, but did not receive a call back.Surveyor placed a call out to the nurse supervisor a message was left on 2/3/26 at 1:15 PM. Surveyor did not receive a call back.On 2/3/26 at 3:07 PM, Surveyor interviewed DON B and ADON C (Assistant Director of Nursing). Surveyor asked DON B and ADON C when they first became aware of R2's wound to her left pinky finger. DON B indicated it wasn't a wound it was a blood blister. DON B and ADON C indicated they became aware of the blood blister first part of December. Surveyor asked DON B and ADON C if they would expect wound assessments initially when a wound is found and then weekly thereafter. DON B and ADON C indicated not on a blood blister. Surveyor asked DON B and ADON C if they could describe R2's left pinky finger the day she was sent to the emergency department. ADON C indicated the pinky finger was swollen and red; it was warm. ADON C indicated there was a hematoma to the left pinky finger. Surveyor asked if the finger had any drainage and ADON C indicated when they removed the splint there was yellow drainage on the splint. Surveyor asked if the drainage came from the swollen area/hematoma. ADON C and DON B indicated no, that they did not know if there was another wound because they could not visibly see due to the contracture of the left hand and swelling. Surveyor asked if the facility determined a root cause for the wound. DON B indicated it was from the splint and the hand contracture, so the splint was discontinued, and a washcloth was ordered per physician. Surveyor asked if the facility has a wound nurse or who is responsible for wounds. ADON C indicated all the nurses are responsible, but the RN supervisor would do the measurements. Surveyor asked DON B if she would expect wound assessments/documentation of R2's wound to the left pinky finger. DON B indicated she would not on a hematoma. The Surveyor pointed out that the swollen left pinky finger per hospital discharge was referred to as an abscess. Surveyor asked if an abscess would be a wound. DON B indicated if the abscess is open and draining it would be. Surveyor asked DON B how one would monitor the abscess for improvement or worsening without wound assessments. DON B indicated they would be assessing it with the daily treatment and the weekly skin assessments. Staff would (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	02/03/2026

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 - Actual harm Residents Affected - Few	notify their supervisor of changes. Surveyor asked DON B if R2's left pinky finger was being monitored prior to the hematoma development. DON B indicated the facility does weekly skin assessments with baths and the CNAs monitor with the palm protector placement and removal. Surveyor asked DON B if she would expect wound assessments to be completed after R2 returned from the emergency department on antibiotic. DON B indicated yes.On 2/4/26 at 8:03 AM, Surveyor interviewed NP D. Surveyor went over the timeline from the date of R2's wound (open area) discovered on 12/10/25 to R2 being sent to emergency department on 12/19/25 with a change of a hematoma noted to R2's left pinky finger and discovering osteomyelitis along with a closed nondisplaced fracture of distal phalanx of left little finger. NP D indicated she does not think there is a fracture. NP D indicated her and the surgeon looked at the radiograph yesterday (2/3/26) and it looks like a shadow. NP D indicated radiographs are typically taken with the hand open, in R2's case the radiograph was taken with the hand clenched shut due to the contracture of the hand. The shadow could be due to the radiograph taken with a closed hand. The only way to know if there is a fracture is to do a repeat radiograph in 4 weeks; the body responds to a fracture by sending calcium to the fracture. On the x-ray you will see all the calcium surrounding the fracture as it lights up on the x-ray. Surveyor asked NP D if she would expect the facility to be monitoring and completing wound assessments on R2's left pinky finger. NP D indicated yes, at least daily. Surveyor asked NP D if she would expect wound assessments to be documented and NP D indicated yes. Surveyor asked NP D in her professional opinion what caused R2's osteomyelitis and NP D indicated the open area. NP D indicated bacteria more than likely entered into the open area. NP D indicated osteomyelitis will spread bone to bone and is very aggressive and hard to treat with oral antibiotics. In R2's case, she is very fragile and not the healthiest and on end-of-life cares. Osteomyelitis will continue to progress from bone to bone. Another concern with osteomyelitis, the bacteria causing osteomyelitis can cause one to become septic. I chose to treat with oral antibiotics to slow the progression of the osteomyelitis down. Surveyor asked if the osteomyelitis could have been prevented and NP D indicated no, with R2 she is nonverbal. Most people with osteomyelitis have a lot of pain and can tell you. (Of note: R2's hospital diagnosis list did not have osteomyelitis listed, however it was referenced.)Staff observed R2's wound on 12/10/25. Staff did not continuously assess, document, and monitor R2's wound. R2 had a change in the wound 9 days later on 12/19/25 where there is a hematoma. R2 was sent to the emergency department and diagnosed with an abscess and closed nondisplaced fracture of distal phalanx of left little finger.