STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525114	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2024

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38882 Based on observation, interview, and record review, the facility did not ensure each resident receives care, consistent with professional standards of practice (SOP), to prevent pressure injuries (PI) and each resident with PIs receives necessary treatment and services, consistent with professional SOP, to promote healing, prevent infection, and prevent new injuries from developing in 1 of 1 sampled residents (R12) out of a total sample of 17 residents reviewed. R12 developed a pressure injury in the facility. Over time, this pressure injury developed an odor, grew in size, and was noted to have an increase in drainage. The facility did not update R12's Medical Doctor (MD) with these changes. Surveyor observed R12 calling out, striking, and wincing in pain during wound care. Staff were unaware R12 had an order for as needed oxycodone to be given prior to wound care. Staff took a defensive approach by placing pillows between R12 and themselves prior to providing wound care and during wound care and staff did not stop when R12 began calling out and striking during wound care. Surveyor observed R12 to be in the same position for extended periods without being repositioned. Surveyor observed R12 to have three or four layers between him and his pressure relieving mattress. Surveyor observed poor hand hygiene during R12's wound care treatment. Staff inconsistently staged R12's wound and left out important details of the wound's drainage and characteristics of the wound bed in weekly assessments, including how much slough covered the wound bed and how much granulation tissue covered the wound bed. Surveyor observed R12 to have his heels directly in contact with the mattress and not offloaded/floated as ordered. The facility's failure to provide care for R12 consistent with current SOP to prevent and treat PIs led to the development of an infected stage 4 PI thus creating a finding of Immediate Jeopardy (IJ) that began on 1/20/24. NHA A (Nursing Home Administrator) was notified of the IJ on 4/18/24 at 5:07 PM. The Immediate Jeopardy was removed on 4/18/24; however, the deficient practice continues at a scope/severity of D (potential for minimal harm/isolated) as the facility implements its removal plan. (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: 525114	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2024
NAME OF PROVIDER OR SUPPLIER Sauk CO Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Evidenced by: Facility policy, entitled Change in Condition, reviewed 4/2024, includes, in part: 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 in condition defined as sudden, clinically important deviation from the resident's baseline in physical, cognitive, behavioral, or functional domains. Clinically important means a deviation that, without intervention, may result in complications or death . When an acute change in condition occurs, the shift supervisor will notify the attending MD or designated alternate . The shift supervisor will document the notification of the MD and the resident/medical contact along with new orders in the resident's record . Pain-The following may indicate an acute change in condition and should be assessed further: pain worsened in severity, intensity, or duration, and/or occurring in a new location, new onset of pain ., new onset of pain greater than 4 on a 10 point scale . please refer to the table of categories of symptoms that may help to define an acute change in condition . Facility policy, entitled Pressure Injury Prevention, reviewed 4/2024, includes: it is the policy of the facility that residents who enter the facility without pressure injuries will not develop pressure injuries unless the clinical condition demonstrates they were unavoidable . and that a resident having pressure injuries will receive necessary treatment and services to promote healing, prevent infection, and prevent new injuries from developing . clinical conditions that this facility identifies as risk factors for development of pressure injuries include but are not limited to: impaired or decreased mobility and functional ability, terminal illness, peripheral vascular disease, diabetes, bowel incontinence, urinary incontinence, history of previous pressure injuries, impaired diffuse or localized blood flow, increased friction or shear, and resident refusal to some aspects of care and treatment . If a resident is admitted or develops a pressure injury, pressure injuries will be staged following the national pressure injury advisory panel pressure injury staging system. Residents will be repositioned at least every two hours to prevent skin breakdown. If an injury is on the resident's buttocks/coccyx area, resident will be repositioned every hour . Lift sheets will be used in bed to decrease friction and shear . heels are free floated for those at high risk .Measurements are completed in terms of length x width. Describe stage of injury per the national pressure ulcer advisory panel. The documentation should include exudates-type, amount, odor . describe wound bed appearance and surrounding tissue . know any signs or symptoms of infection . assess for signs and symptoms of discomfort. If discomfort is present during dressing change: stop immediately and offer analgesic to decrease discomfort. Whenever possible premedicating should occur to prevent discomfort . dressing changes: wash hands, assemble dressing supplies, use barrier between dressings and table for infection control purposes, open dressing supplies and prepare for use, apply gloves, remove dressing and dispose in waste receptacle, note any drainage or odor, remove gloves, wash hands, apply gloves, cleanse wound from clean to dirty, pat dry, measure wound, apply treatment per MD order, cover with dressing, secure with tape, remove gloves, wash hands . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525114	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2024
NAME OF PROVIDER OR SUPPLIER Sauk CO Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Facility policy, entitled Wound Treatment Management, reviewed 4/2024, includes: to promote wound healing of various types of wounds it is the policy of the facility to provide evidence-based treatments in accordance with current standards of practice and physician orders . the effectiveness of treatments will be monitored through ongoing assessment of the wound. Considerations for needed modifications include lack of progress towards healing, changes in the characteristics of the wound . characteristics of the wound: pressure injury stage or level of tissue destruction . size-including shape depth and the presence of tunneling or undermining, volume and characteristics of exudate, presence of pain, presence of infection or need to address bacterial bioburden, condition of the tissue in the wound bed, condition of [NAME] wound skin . Facility policy, entitled Hand Hygiene, reviewed 4/2024, includes: .hand hygiene . as the single most effective means of preventing the spread of infection . hand hygiene is the responsibility of all employees . when to wash your hands: . before and after each direct contact with residents . after handling waste materials with secretion, drainage, or blood . after glove removal, after handling soiled linen . AMDA Clinical Practice Guidelines/Interact Tool for Change In Condition, dated 2014, includes: When to report to the MD . Immediate Notification-any symptom, sign, or apparent discomfort that is: acute or sudden in onset, and a marked change in relation to usual symptoms or signs or unrelieved by measures already prescribed . Non-Immediate Notification-new or worsening symptoms that do not meet above criteria . The National Pressure Ulcer/Injury Advisory Panel's Standards of Practice for Pressure Ulcer Prevention Points and Pressure Injury Stages, dated 2016, includes: Reposition bed-bound persons at least every two hours and chair-bound persons every hour (emphasis intended.) consistent with overall goals of care . Use devices that eliminate pressure on the heels. For short-term use with cooperative patients, place pillows under the calf to raise the heels off the bed. Place heel suspension boots for long-term use. According to the NPUAC, Pressure Ulcer Assessments should be done initially and re-assessed at least weekly and to document the results of all wound assessments. A two-week period is recommended for evaluating progress toward healing. Signs of deterioration (e.g., increase in wound dimensions, change in tissue quality, increase in wound exudate or other signs of clinical infection) should be addressed immediately . Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink, or red, moist, and may also present as an intact or ruptured serum-filled blister. Stage 3 Pressure Injury: Full-thickness skin loss Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. Stage 4 Pressure Injury: Full-thickness skin and tissue loss Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage, or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525114	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2024
NAME OF PROVIDER OR SUPPLIER Sauk CO Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	According to the National Pressure Ulcer Advisory Panel (NPUAP), dated 6/13/12, recommends use of positioning devices and incontinence pads that are compatible with the support surface and to limit the amount of linen and pads placed on the bed. They also direct clinicians not to leave moving and handling equipment under the individual after use. American Medical Directors Association (AMDA) guideline for the cause, prevention, and treatment of pressure sores, undated, includes: Use adequate pain control measures including additional dosing at the time of debridement or dressing changes . R12 admitted to the facility on [DATE]. He has diagnoses including nonverbal vascular dementia, severe Peripheral Arterial Disease with ischemic necrosis of foot, large left popliteal aneurysm and embolization of a right popliteal aneurysm resulting in acute ischemia, Diabetes Mellitus Type 2, cerebral vascular accident, expressive aphasia, and prostate cancer. R12's Comprehensive Care Plan, initiated 9/9/17, includes: 4/10/19 inspect skin especially bony prominences and dependent areas for redness, breakdown . Provide pressure reduction/relief mattress on bed and pad/cushion in wheelchair, heel and elbow protectors if indicated. Assess skin status, assess nutrition, keep MD (Medical Doctor) informed, administer analgesics as ordered . 12/4/20 nail care by nurse . observe for non-verbal signs and symptoms of discomfort . 3/1/21 lift and move resident carefully and with adequate assistance to prevent shearing of skin. Keep skin clean and dry, encourage and assist to reposition, report changes in skin to nurse, give incontinence care after each episode of incontinence, apply moisturizer and barrier as needed, inspect skin daily, positioning pillows as needed, air mattress, rolling pin . assist resident toileting every 2 hours and as needed . 9/27/23 assess and monitor for changes in skin injury . weekly . Clean, apply medication and dress open area as ordered. Daily inspection of skin including bony prominences and dependent areas for redness or breakdown. Keep clean and dry, monitor for drainage, color, odor . Ensure proper positioning of absorbent products/cath strap. Encourage mobility of extremities and reposition every 2 hours, reposition hourly if up in chair and wound is on seating surface. If possible, avoid seating resident on wound area, limit seating time in chair as tolerated, give incontinence care after each episode . apply moisture, apply barrier . Keep skin clean and dry, change wet linen, use incontinence pads, barrier cream to peri area as needed. Report changes in skin to nurse. Float heels and use pillows to maintain lateral position and separation of bony prominences. 12/4/23 Problem: infection to right digit (toe), necrotic, poor circulation . Use good hand hygiene techniques before and after cares . 12/28/23 Diabetes Mellitus, immobility, Hoyer lift transfer . Assess and monitor for changes in skin injury on weekly flow sheet. bony prominences and dependent areas for redness or breakdown. Keep clean and dry, monitor for drainage, color, odor . Pressure relieving device in chair, pressure relieving device for bed, applications of dressings . 2/7/24 Problem: infected Decubitus Sacral Ulcer . related to poor skin condition, diabetes mellitus, poor vascular condition . Manifested by drainage, warmth, and redness . Goal: free of signs of infection . Interventions: Nurse-Use good hand washing technique before and after cares. Wear gloves with cares. Note characteristics of drainage. Monitor labs as ordered . CNA-Use good hand washing techniques before and after cares, keep area clean and dry, help resident to wash hands, assist resident with turning every 2 hours, encourage fluid intake . use enhanced barrier precautions. 3/29/24 nail care by nurse, transfer-2 assist with Hoyer . repositioning/bed mobility- 1 assist, head of bed at 30 degrees or less, reposition at least every 2 hours, broda chair . skin-keep skin clean and dry, report changes in skin to nurse . cognition-alert and oriented times 1 . R12's Nurse Notes, dated 10/4/23, indicate R12 has an open wound on buttock. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525114	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2024
NAME OF PROVIDER OR SUPPLIER Sauk CO Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R12's Minimum Data Set (MDS), with Assessment Reference Date (ARD) of 10/6/23, indicates R12 requires substantial maximal assistance with rolling left to right and his helper does more than half the work. R12's MDS also indicated he is dependent on staff assistance to transfer from his bed to chair or chair to bed. R12's MDS indicates he receives scheduled pain medication for pain and the facility does not use non-pharmaceutical interventions for pain. R12's MDS states the facility should use facial expressions as indicators of pain and R12 was observed to have pain 1 or 2 days out of the 5 days observed. R12's Braden Scale Skin Assessment, dated 10/9/23, includes a score of 17, indicating high risk . Moisture-occasionally moist, skin is occasionally moist, requiring an extra linen change approximately once a day. Activity-chairfast . Mobility-slightly limited . can't bear weight or assisted to chair or wheelchair . Friction/shear-potential problem . some sliding with repositioning . occasionally slides down in chair/bed . R12's Nurse Notes, dated 10/11/23, indicate R12's open area to buttock is no longer open and they are treating with daily barrier cream as prevention. R12's Nurse Notes, dated 10/19/23, indicate R12 has a new area of shearing to right buttock and staff were educated on the proper use of a Hoyer sling. The area is measuring 1.4cm x 0.9cm x 0.1cm with drainage that is light, less than 25% serous. The wound bed consists of granulation tissue while the surrounding skin is intact. It also indicates R12 is on a turning/repositioning program, receives applications of ointment/medications, receives application of dressings. R12's Nurse Notes indicate the MD (Medical Doctor) order is as follows: the area is to be cleansed with normal saline solution, patted dry, apply Medihoney, and covered with Mepilex border every three days and as needed until healed. R12's Nurse Notes, dated 10/25/23, indicated the area measures 1.3cm x 0.5cm x 0.1cm. The drainage is light with less than 25% serosanguineous. There is no odor. The wound bed consists of granulation tissue. R12 has pressure relieving device for chair and pressure relieving device for bed, is on a turning/repositioning program, is receiving ulcer care and application of dressings, and incontinence care. R12's Nurse Notes, dated 11/3/23, includes in part: Mepilex border changed to coccyx, Medihoney applied per order. Scant amount of serous drainage noted on old Mepilex dressing . [NAME] slough noted to wound bed. (It is important to note this is the first mention of slough in the wound bed and it does not contain how much of the wound bed is covered in slough. The staff have reported granulation tissue in wound bed up until this point. Surveyor found no evidence of R12's MD being updated with this worsening status/change in the wound's wound bed.) R12's Nurse Notes, dated 11/7/23, include sheared area to buttocks . 1.8cm x 1.4cm x less than 0.1cm . light drainage less than 25% serosanguinous . odor-none . wound bed: granulation tissue, surrounding skin: intact . (It is important to note the wound is showing an increase in size from the last documented measurements.) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525114	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2024
NAME OF PROVIDER OR SUPPLIER Sauk CO Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R12's MD Progress Note, dated 11/8/23, includes Buttock lesion . Has had it for 2 weeks . Shear type injury as slid down in bed. Using Medihoney and Mepilex currently per wound team. Buttocks with two lesions, central one is over tailbone, with erythematous base, no significant discharge currently. Several layers deep, approximately 2cm x 1 cm. Lesion on left buttock, very superficial, with overlying light eschar, also approximately 1cm x 2cm. R12's Nurse Note, dated 11/15/23, includes partial thickness skin loss with exposed dermis stage 2 pressure right medial buttock . 1.5cm x 1.0cm x 0.1cm scant serous . no odor . wound bed-granulation tissue . surrounding tissue-intact, fragile . R12's Nurse Notes, dated 11/22/23, include sheared area to coccyx . 2cm x 1cm x 0.1cm . drainage-scant serous .Odor-no odor . wound bed-yellow slough, granulation tissue . surrounding skin-intact, fragile .the length was 1.5cm last week and this week it is 2.0 cm . R12's Nurse Notes, dated 11/29/23, include sheared area to coccyx . 2cm x 1cm x 0.1cm. Drainage: scant serous, Odor-no odor . Wound bed-yellow slough, granulation tissue . surrounding skin-intact, fragile . (It is important to note the description of the wound bed lacks how much slough and granulation tissue was observed to be present in the wound bed.) R12's Nurse Notes, dated 12/6/23, include sheared area to coccyx . 1.5cm x 0.5cm x less than 0.1 cm . Drainage-scant serous drainage . Wound bed-yellow slough, granulation tissue . Surrounding tissue is intact, fragile . (It is important to note the description of the wound bed lacks how much slough and granulation tissue was observed to be present in the wound bed.) R12's MD Progress Note, dated 12/13/23, includes: buttocks wound measuring 1.5cm x 0.5cm x 0.1cm . is currently being treated with Medi-honey and coverage every three days . No signs of infection and decreasing in size . Pressure ulcer-overall improving-staff applying Medihoney . R12's Podiatrist Note, dated 12/21/23, includes Resident remains on antibiotics . (It is important to note R12 is also being treated for foot ulcers/osteomyelitis in his left foot at this time and is receiving antibiotics for this.) R12's Nurse Notes, dated 12/25/23, include open area to sacrum 5cm x 1.5cm. Wound bed had yellow slough in it . Wound treatment completed per order. Open area to left buttocks 1cm x 0.5cm . Cleansed area with normal saline. Applied Mepilex. (It is important to note there are 2 areas being measured now. It is also important to note the size increase since the last measurement.) R12's MD Progress Note, dated 12/26/23, includes new order: Duoderm to wound on buttocks. Change every 3 days until healed . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525114	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2024
NAME OF PROVIDER OR SUPPLIER Sauk CO Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0686

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

R12's MDS, with ARD 1/1/24 indicates R12 requires substantial/maximal assist when rolling left to right bed mobility and is dependent on staff assistance when transferring from bed to chair or chair to bed. R12's MDS indicates he is on scheduled pain medications. He did not take any as needed pain medications and the facility is not using non-pharmaceutical interventions related to R12's pain. R12's MDS also indicates his pain indicators are facial expressions, protective body postures/movement, rubbing area of pain, and clutching or holding of body part. The frequency of R12's pain is as follows: R12 was observed to have pain 1-2 days out of 5 observed.

R12's Nurse Notes, dated 1/4/24, include sheared area to right buttocks, 2 areas: first area-4.5 cm x 2cm x 0. 2 cm . Drainage-light drainage, less than 25% serosanguineous . Wound bed-yellow slough, granulation tissue. Surrounding skin-intact, blanchable .

second area-located directly next to large area - 1.5cm x 0.3cm x less than 0.1 cm . Drainage- light, less than 25% serosanguinous . Wound bed-yellow slough, granulation tissue . Surrounding skin intact, blanchable .

(It is important to note the description of the wound beds lacks how much slough and granulation tissue was observed to be present in the wound bed.)

R12's Nurse Note, dated 1/10/24 includes 4.6cm x 1.5cm x 0.2cm . Drainage-moderate 25-75% serosanguinous . Odorous-foul . Wound bed-yellow slough yellow . Surrounding tissue-fragile . worsening, becoming larger, becoming deeper .

(It is important to note only one area is measured this time, not two and there is a reported foul odor in the wound.)

R12's MD Progress Note, dated 1/10/24, includes attending MD examined client: new orders for Santyl to coccyx wound daily . consult with Infectious Disease for coccyx wound and coordinate with podiatrist appointment .

According to <https://santyl.com/hcp/dosing> Important Safety Information

Indication: Collagenase SANTYL Ointment (SANTYL) is indicated for debriding chronic dermal ulcers and severely burned areas. Contraindications: Debilitated patients should be closely monitored for systemic bacterial infections because of the theoretical possibility that debriding enzymes may increase the risk of bacteremia. (Emphasis intended.)

R12's Hospital Note, dated 1/10/24, includes pressure ulcer worsening currently unstageable due to slough present. Already on antibiotics which should cover typical staph/strep. Concern for possible fungal component. Will start enzymatic and place referral for wound consult. Ongoing pressure ulcer to buttocks. Began as a shear injury. Last one to two weeks has gotten significantly worse and deeper. Prior was placing Duoderm. Recently changed to Medi-honey with Mepilex. Wound care/dietary with recent request for additional supplements vitamin C and zinc. I did ok zinc but only for 10 days given high dose request . evidence additional can be detrimental. Resident is in bed. Has been in bed except for meals due to pressure. Groans when we do buttock exam but otherwise allows treatment. Buttock upper portion shallow. Erythematous. Lower portion significantly deeper with right pitting white base looks like slough .

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525114	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2024
NAME OF PROVIDER OR SUPPLIER Sauk CO Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	(It should be noted the antibiotics are for the foot infection. The PI was not cultured at this time to ensure sensitivity to current antibiotic.) R12's Nurse Note, dated 1/17/24, includes, Partial thickness skin loss with exposed dermis . pressure stage 2 . obscured full thickness and tissue loss . unstageable . location-coccyx . 2 cm x 1cm x changed depth . odorous none . Wound bed-black eschar . (It is important to note the two different stages named in this note for this one wound and the wound bed lacks the description of how much of the wound bed is covered by black eschar.) R12's Nurse Notes, dated 1/18/24, includes removed previous dressing to coccyx, rinsed with normal saline solution, applied Santyl cream, applied dressing and taped, no change to wound, slough still present on wound bed, no signs of infection, no odor noted . (It is important to note this note says slough to the wound bed while 1/17/24 note says black eschar to the wound bed.) R12's Nurse Note, dated 1/19/24, includes buttock treatment done per MD order. Wound is heavy with yellow slough. Surrounding tissue is intact. No signs of infection noted. (It is important to note the description of wound is heavy with yellow slough. There is no evidence of R12's MD being notified of this change in wound status.) R12's Nurse Note, dated 1/20/24, includes dressing to coccyx, rinsed with normal saline solution, applied Santyl cream, applied dry dressing and taped, no change in wound, slough still present on wound bed, no signs of infection, odor noted. (It is important to note an odor was noted and there is no evidence of R12's MD being notified of this change in wound status.) R12's Nurse Note, dated 1/21/24, includes removed previous dressing to coccyx, small amount of drainage noted to previous dressing, rinsed with normal saline solution, applied Santyl cream, applied dry dressing and taped, slough still present on wound bed, no signs of infection, odor is noted . refused change in position-called staff (explicit language) . (It is important to note there is an odor noted and R12's MD is not being notified of this wound status. It is also important to note R12 is refusing position changes and is calling staff explicit names while his documented indicators for pain, on his 1/1/24 MDS, are facial expressions, protective body postures/movement, rubbing area of pain, and clutching or holding of body part. There is no evidence of R12's MDS being updated on these nonverbal indicators of pain or his refusal of care.) R12's Nurse Notes, dated 1/22/24, indicate R12's MD was notified due to respiratory symptoms and positive results of his COVID 19 test. The following skin measurements were taken after the MD notification was documented . coccyx . 4cm x 2.5cm, depth undermining . Drainage-moderate drainage 25-75%, Odorous-strong . Wound bed-yellow slough, tunneling . Surrounding tissue-intact, reddened, fragile . worsening . becoming larger, becoming deeper, sloughing occurring tenderness present . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525114	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2024
NAME OF PROVIDER OR SUPPLIER Sauk CO Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	(It is important to note the facility did not provide evidence of R12's MD being notified of the wound status changes including the larger size, the depth now undermining, and the strong odor.) R12's Nurse Note, dated 1/23/24, includes refused some cares . kicking, upset . buttocks dressing changed per order. Moderate amounts of serous drainage present. Slight foul odor noted . (It is important to note staff are still documenting the wound has an odor and there is still no MD notification.) R12's Podiatrist Progress Note, dated 1/24/24, includes remains on antibiotics until assessment during next appointment. (Of note R12 continues on the antibiotic for his foot yet staff document increased odor in R12's PI. Santyl has a contraindication for causing bacteremia in debilitated patients.) R12's Nurse Notes, dated 1/26/24, includes buttock treatment done per MD order. Wound is heavy with yellow slough. Surrounding tissue intact. No signs of infection noted. R12's Nurse Notes, dated 1/29/24, include removed previous dressing to coccyx, small amount of drainage noted to previous dressing, rinsed with normal saline solution, applied Santyl cream, applied dry dressing and taped, no signs of infection, odor is noted . R12's Hospital Notes, 1/30/24, include imaging: CT (imaging of soft tissue) pelvis with contrast: impression soft tissue defect dorsal to the distal sacrum and proximal coccyx. CT is not the most sensitive study for the detection of underlying osteomyelitis. Consider either an MRI (magnetic resonance imaging/imaging of bone) of the bony pelvis and/or a limited three phase bone scan to the pelvis and lower extremities. R12's Hospital Notes, dated 1/31/24, include the palliative care medicine service was asked by MD to provide consultation for R12 to elucidate goals of care in order to aid in assistance with code status, advanced directives, and or appropriate surrogate. Goals of care to get him back to baseline . to heal the wound up . guardian open to aggressive measures including Intensive Care Unit level care, blood transfusions, etc. would need to further discuss the idea of surgery and or vasopressors depending on indications for each. Palliative care will continue to follow for emotional, spiritual, psychosocial support and symptom management . R12's activated power of attorney does think he's in pain . of note he does have metastatic prostate cancer with bone lesions seen upon diagnosis . was on leuprolide. We did discuss concern for patient surgery and poor wound healing as well as concern for being more sedentary with increased pain post op and worsening sacral ulcer. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525114	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2024
NAME OF PROVIDER OR SUPPLIER Sauk CO Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R12's Hospital Notes, dated 2/1/23, include asked to be seen by MD regarding a sacral decubitus ulcer. He is a complex patient with non-verbal vascular dementia and multiple other medical issues. He is admitted for IV (intravenous) antibiotics to treat a sacral decubitus ulcer. On inspection, there is some necrotic tissue in the wound. It does not appear too deep, but it could be down to the sacrum as there is not much tissue depth in that area. This can be surgically debrided while he is in the hospital. He will need to be off Apixaban (blood thinner) for 2 days prior to having surgery . There is a 2cm x 3 cm sacral decubitus ulcer present . The patient can have debridement scheduled in the operating room but would need to be off apixaban (blood thinner) prior to surgery He was seen by NP (Nurse Practitioner/name) in clinic 2 days ago and due to the concern over osteomyelitis of the residual wound as well as a very deep and necrotic sacral decubitus ulcer, was recommended for admission. R12's Hospital Notes, dated 2/3/24, includes Surgery General: rolled on to the table in a left lateral decubitus position. The wound was about 3cm by 2cm in diameter and 2cm deep. There was a mixture of dead and viable tissue in the wound and there was a foul odor. The non-viable tissue was removed with sharp and cautery dissection. This included epidermis, dermis, subcutaneous tissue, and fascia. The wound was irrigated and then packed with gauze. Of note, the description of removal of fascia indicates R5 had a full-thickness tissue loss indicating a Stage IV PI. According to NPIAP a Stage 4 Pressure Injury is defined as a Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage, or bone in the ulcer. R12's Hospital Discharge Orders, dated 2/6/24 include: Oxycodone HCI 5mg . Tablet by mouth . Take 1 twice a day as needed. Give prior to wound cares for pain . (Emphasis Intended.) (It is important to note the hospital note, dated 1/30/24, states there is a concern for R12 being more sedentary with increased pain post operation. It is also important to note the many different times in different places it is documented that R12 is noncommunicative. As of 2/6/24, R12 has an order for as needed pain medication to be administered prior to wound care. R12 will not be able to ask for this pain medication, staff will need to anticipate this care need for him. R12's MDS indicates his pain indicators.) R12's Hospital Notes, dated 2/6/24, include the following: admitted [DATE] . discharged [DATE] . Infected decubitus sacral ulcer, DM Type 2, Malignant Prostate Neoplasm, Osteomyelitis of 2nd toe . Augmentin ordered two times a day through 2/17/24 . Infectious Disease Wound Clinic follow up . physical therapy/occupational therapy consult . frequent position changes on/off loading wound . non healing infected sacral wound having failed outpatient management with local wound cares and 500mg cephalexin two times a day . admitted for treatment of infected decubitus sacral ulcer. Contributed to by chronic immobility, advanced dementia with expressive aphasia, and sev [TRUNCATED]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525114	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2024
NAME OF PROVIDER OR SUPPLIER: Sauk CO Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38882 Based on interview and record, the facility did not ensure that 4 of 4 sampled residents (R1, R12, R13, and R35) received treatment and care in accordance with professional standards of practice for foot care. The facility failed to provide diabetic foot checks daily in accordance with current standards of practice. The facility did not have a policy reflecting the current standards of practice related to diabetic foot checks. Evidenced by: Facility policy, entitled Skin Integrity-Foot Care, reviewed 4/2024, does not reflect current standards of practice related to daily diabetic foot checks completed by a nurse or someone with education to perform assessments. Per the American Medical Directors Association - The Society for Post-Acute and Long-Term Care Medicine. Pressure Ulcers. Clinical Practice Guideline, dated 12/9/14, includes, in part: http://www.amda.com/tools/guideline.cfm#pressureulcer .to the extent feasible, caregivers should educate patients about daily foot care .Treatment of foot problems in patients with diabetes is generally stratified into three broad risk categories: at-risk foot; current mild foot, ankle, or heel infection or ulcer; and limb-threatening foot, ankle, or heel infection or ulcer . Treatment of foot problems in patients with diabetes is generally stratified into three broad risk categories: at-risk foot . has neuropathy .vascular insufficiency .cannot see, feel, or reach their feet .Treatment Plan . Refer for podiatric care at least annually and as needed for specific foot problems . Train caregivers to perform daily foot care and inspection . Risk Category: At-risk foot (patients who smoke; have vascular insufficiency, neuropathy, retinopathy, nephropathy, history of ulcers or amputations, structural deformities, infections, skin/nail abnormality; are on anticoagulation therapy; cannot see, feel, or reach their feet.) Treatment Plan: Refer for podiatric care at least annually and as needed for specific foot problems . Train caregivers to perform daily foot care and inspection . To the extent feasible, train patients to perform daily foot care and inspection . Example 1 R1 admitted to the facility on [DATE] and has diagnoses, including Type 2 Diabetes Mellitus with diabetic neuropathy. R1's Medication/Treatment Administration Record (MAR/TAR) for [DATE], February 2024, March 2024, and April 2024 includes 5/7/19 Foot Exam 2 times monthly by nurses-Nurse to cut and file finger and toe nails on the PM shift every 2nd and 4th Tuesday., indicating the facility is not performing daily diabetic foot checks. R1's Physician Orders, January 2024, February 2024, March 2024, and April 2024, indicate there is no order for daily diabetic foot checks. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525114	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2024
NAME OF PROVIDER OR SUPPLIER Sauk CO Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R1's Comprehensive Care Plan, initiated 4/30/2019, indicates staff are not performing daily diabetic foot checks on R1. Example 2 R12 admitted to the facility on [DATE]. He has diagnoses, including nonverbal vascular dementia, severe Peripheral Arterial Disease with ischemic necrosis of foot, large left popliteal aneurysm and embolization of a right popliteal aneurysm resulting in acute ischemia, Diabetes Mellitus Type 2, cerebral vascular accident, expressive aphasia, and prostate cancer. R12's Physician Orders, January 2024, February 2024. March 2024, April 2024, indicate there is no order for daily diabetic foot checks. R12's MAR/TAR for January 2024, February 2024, March 2024, and April 2024 include: 9/9/17 Foot exam two times monthly by Nurse- nurse to cut and file finger and toe nails on PM shift every 2nd and 4th Friday, indicating the facility is not providing daily diabetic foot checks per current standards of practice. R12's Comprehensive Care Plan, initiated 9/9/17, does not have any goals or interventions related to daily diabetic foot checks. Example 3 R13 admitted to the facility on [DATE] and has the following diagnoses: Type 2 Diabetes Mellitus with diabetic chronic kidney disease, long term use of insulin, and a personal history of disease of the skin and subcutaneous tissue/stage 2 pressure ulcer to right buttock. R13's Physician Orders, January 2024, February 2024, March 2024, and April 2024 indicated there is no order for daily diabetic foot checks. R13's MAR/TAR, January 2024, February 2024, March 2024, and April 2024, include: 4/27/21 Foot exam two times monthly by Nurse- nurse to cut and file finger and toenails on PM shift every 2nd and 4th Tuesday, indicating the facility is not providing daily diabetic foot checks per current standards of practice. R13's Comprehensive Care Plan, initiated 4/27/21, does not include interventions or goals related to daily diabetic foot checks. Example 4 R35 admitted to the facility on [DATE] and has a diagnosis including Type 2 Diabetes Mellitus. R35's Physician Orders for January 2024, February 2024, March 2024, and April 2024 indicated there is no order for daily diabetic foot checks. R35's MAR/TAR, January 2024, February 2024, March 2024, and April 2024, include: 4/12/21 Foot exam two times monthly by Nurse- nurse to cut and file finger and toenails on PM shift every 1st and 3rd Fridays, indicating daily diabetic foot checks are not completed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525114	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2024
NAME OF PROVIDER OR SUPPLIER Sauk CO Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R35's Comprehensive Care Plan, initiated 4/12/21, does not include interventions or goals related to daily diabetic foot checks. On 4/17/24 at 4:31 PM, RN F (Registered Nurse) indicated diabetic foot checks are done weekly on the resident's bath day. On 4/17/24 at 4:35 PM, RN G indicated diabetic foot checks are completed two times a month and are scheduled on the resident's MAR/TAR. On 4/17/24 at 4:39 PM, RN H indicated diabetic foot checks are not done daily, but they are done every two weeks and they pop up on the MAR/TAR when they are due. On 4/17/24 at 4:46 PM, DON B (Director of Nursing) indicated she was unaware of the current standard of practice for daily diabetic foot checks. DON B indicated the CNAs (Certified Nursing Assistants) check feet regularly, but the nurses check once a week with bath schedules and twice a month for performing nail care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525114	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2024
NAME OF PROVIDER OR SUPPLIER Sauk CO Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44552 Based on observation and interviews, the facility failed to serve food at an appetizing temperature. This has the potential to affect 2 of 17 sampled Residents (R32 and R3) and 2 of 3 supplemental Residents (R36 and R20). R3, R32, R36, and R20 voiced concerns that hot food was not always served hot and cold food was not served cold. 1 of the 2 test trays temped failed to meet appropriate temperatures. Evidenced by: The facility policy, Food Temperatures, with a revised date of, 4/2024, states, in part; .All hot food items must be cooked to appropriate internal temperatures, held and served at a temperature of at least 135 F All cold food items must be maintained at served at a temperature of 41 F or below Example 1 On 4/18/24 at 8:01 AM, the kitchen delivered breakfast on B Hallway. Surveyor requested the last tray on the cart. Dietary Aide provided Surveyor the last tray. The tray had French toast sticks, bacon, yogurt, and crushed strawberries. French toast sticks temped at 102.3 F and were hard. No concerns with bacon and yogurt. Crushed strawberries temped at 60 F. Example 2 R32 was admitted to the facility on [DATE]. R32's most recent Minimum Data Set (MDS), dated [DATE], indicates a Brief Interview for Mental Status (BIMS) of 15 indicating R32 is cognitively intact. On 4/18/24 at 8:40 AM, R32 indicated breakfast items that are supposed to be hot are often served warm or cold. R32 said the French toast sticks and pancakes are often cold. R32 indicated R32's breakfast was cold this morning. Example 3 R36 was admitted to the facility on [DATE]. R36's most recent MDS, dated [DATE], indicates a BIMS of 15 indicating R36 is cognitively intact. On 4/18/24 at 8:30 AM, R36 indicated breakfast was cold this morning. R36 indicated the French toast sticks and bacon were cold. R36 indicated crushed strawberries were not cold and are supposed to be cold. R36 indicated staff would heat items up for R36, but it gets so busy during mealtimes. Example 4 R20 was admitted to the facility on [DATE]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525114	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2024
NAME OF PROVIDER OR SUPPLIER Sauk CO Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R20's most recent MDS, dated [DATE], indicates a BIMS of 13 indicating R20 is cognitively intact. On 4/18/24 at 8:35AM, R20 indicated R20's breakfast was cold this morning. R20 indicated R20 had French toast sticks and they were cold and hard. On 4/18/24 at 11:29AM, DM C (Dietary Manager) indicated DM C would expect hot foods served hot and cold foods served cold. DM C indicated understanding when discussing breakfast tray temps. DM C indicated the crushed strawberries should be served cold. DM C indicated the facility wants to get back to serving meals in the kitchenette areas to improve the temps of meals. DM C indicated DM C is aware of the concerns with the temperature of meals. The facility failed to ensure hot foods were served hot and cold foods were served cold. 39849 Example 5 R3 indicated hot foods are not served hot. R3 was admitted to the facility on [DATE]. R3's most recent Minimum Data Set (MDS), dated [DATE], indicates a Brief Interview for Mental Status (BIMS) score of 15. Indicating R3 is cognitively intact. On 4/15/24 at 2:59 PM, during the initial screening process, R3 informed Surveyor that at times the food is not warm enough. R3 indicated that it happens almost every day and there is no specific meal time related to this. R3 indicated staff will warm it; however, feels it shouldn't have to warmed so often.