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	04/07/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 49436 Based on interview and record review, the facility did not implement policies and procedures to prohibit and prevent abuse for 1 of 8 staff reviewed for caregiver background checks. LPN G (Licensed Practical Nurse) was hired on 12/3/24 and had lived in one other state within the last three years. LPN G's background check information did not contain an out-of-state criminal background check. This is evidenced by: The facility's Prevention/Reduction of Resident Abuse, Neglect, Exploitation or Misappropriation of Property policy, revised 05/19 and reviewed 10/24, indicates in part: Employee Screening and Training .d. A criminal background check will be conducted on all prospective employees as provided by the facility's policy on criminal background checks. The facility's Care Giver Background Investigations policy, reviewed/revised on 03/21/14, indicates in part: As applicable, other documentation will be obtained by the entity when information is needed to complete the background check, such as out of state's conviction records when a 'caregiver' has lived out of the state in the last three years, military discharge papers, arrest and conviction disposition information from local clerks of courts or tribal courts, etc. On 3/24/25, Surveyor reviewed LPN G's background check information. LPN G's date of hire was 12/3/24. LPN G's Background Information Disclosure (BID) was completed on 11/19/24. The BID indicated LPN G had resided outside of Wisconsin within the last three years. Surveyor reviewed all background check information and noted an out-of-state criminal background check was not included for the state LPN G had resided in. On 3/25/25 at 10:00 AM, Surveyor requested LPN G's out-of-state background check from NHA A (Nursing Home Administrator). NHA A indicated the facility did not complete an out-of-state background check for LPN G and acknowledged that they should have.

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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** 50698 Based on interview and record review, the facility did not ensure a resident received care, consistent with professional standards of practice, to prevent pressure ulcers for 1 of 3 residents (R) reviewed for pressure injuries (R19). R19 was at risk for developing pressure injuries (PI) related to decreased mobility, bilateral above knee amputation, and radiation therapy. R19 developed a facility-acquired stage 3 PI. The facility did not identify or stage this as a PI but considered it a chronic wound, identifying the root cause was related to friction and shearing from the use of a slide board transfer. The facility continued to use the slide board transfer until after R19 had a EpiFix flap procedure to heal the PI. Additionally, R19 was known to use a rolled washcloth under his hip which the facility also identified as contributing to the PI. Despite these known risk factors, the facility continued to utilize the slide board and failed to provide documented risk vs. benefits to R19 regarding continued use of the slide board and use of the washcloths. R19 developed a facility acquired stage 3 PI, which deteriorated, became infected, and required an EpiFix graft in an attempt to heal the PI. The facility's failure to use an alternative transfer method to the slide board and failure to provide resident with risk vs. benefits of continued use of the slide board led to a finding of immediate jeopardy that began on 3/12/25. NHA A (Nursing Home Administrator) was notified of the immediate jeopardy on 3/31/25 at 12:38pm. The immediate jeopardy was removed on 3/31/25 and continues at a scope/severity of D (Potential for harm/isolated). Findings include: The facility's policy titled Pressure Injury Prevention reviewed 4/2024 states in part: 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, semi-comatose or comatose, COPD, peripheral vascular disease, diabetes, bowel incontinence, urinary incontinence or chronic voiding dysfunction, paraplegia, quadriplegia, sepsis, terminal cancer, chronic or end-stage renal, liver and/or heart disease, disease or drug-related immunosuppression, body cast, malnutrition, dehydration, moderate to severe cognitive impairment, use of psychotropic medication, steroid therapy, radiation therapy, chemotherapy, renal dialysis, history of pressure injuries, impaired diffuse or localized blood flow, increased friction or shear, resident refusal to some aspects of care and/or treatment, and head of bed elevated majority of day due to medical necessity . Assessment: C. If a resident is admitted or develops a pressure injury, pressure injuries will be staged following the National Pressure Injury Advisory Panel (NPIAP) pressure injury staging system. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Per the NPIAP, a pressure injury is defined as .localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue. NPIAP definitions include: 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. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. R19 was admitted to the facility on [DATE]. Diagnoses include: malignant neoplasm of prostate (prostate cancer), non ST elevation myocardial infarction (a serious heart attack that occurs when blood supply to the heart is reduced causing damage), hypertensive heart disease with heart failure, venous insufficiency, cerebral ischemic attacks and related syndromes (strokes, occurs when blood flow to the brain is interrupted causing brain cells to die), peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs) and thrombocytopenia (low platelet level in blood). R19's most recent Minimum Data Set (MDS), dated [DATE], includes a Brief Interview for Mental Status (BIMS) score of 15, indicating R19 is cognitively intact. Facility completed an additional BIMS on 3/28/25 and R19's score was also 15. Surveyor reviewed MDS assessments for R19 going back to facility's last recertification survey which was completed on 5/1/24. *On the Annual MDS completed 5/8/24, Section M indicates no unhealed pressure ulcers. *Quarterly MDS completed on 8/9/24, Section M indicates 1 unhealed pressure ulcer, stage 2. *Quarterly MDS completed on 11/12/24, Section M indicates no unhealed pressure ulcers. *Quarterly MDS completed on 2/12/25 indicates no unhealed pressure ulcers. Although the facility selected no unhealed pressure ulcers on 3 of the 4 MDS assessments, Surveyor noted observed R19 had weekly wound measurements during those months for a left buttock wound. R19's care plan dated 3/26/20 states in part: Problem: Self Care Deficit .3/19/25, Special Approaches: . enhanced barrier precautions .Transfer: 2 Assist Hoyer .Repositioning/Bed Mobility: Assist of 1 person, minimal, bilateral grab bars to aid in repositioning .Toileting: I use urinal, slide board A of 1 person .Skin: Roho Cushion, Encourage/Reposition q (every) 2 hours, keep skin clean and dry, apply moisturizer, report changes in skin to nurse .3/10/2020, Problem: Potential for incontinence, Pericare when incontinent .cleanse peri area and apply barrier cream after incontinent episodes and PRN (as needed), Incontinence check every hour .11/13/2022, Manifested by: potential for abraded/open skin, fragile skin .11/13/2023, Related to: mobility deficit, diuretic usage, bladder flow obstruction, slide board use, prostate CA (cancer) .11/12/2020, (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Problem: 5/28/2020, Potential for Tissue integrity impairment .2/12/2025, Roho cushion .Reposition every 2 hours; lift and move resident carefully and with adequate assistance to prevent shearing of the skin .Keep skin clean and dry .give incontinence care after each episode of incontinence; apply moisturizer and moisture barrier PRN. Utilize draw sheet for positioning/turning. Position pillows as needed, Room safeguards: Air mattress, Apex cushion to w/c .3/10/2020, Problem: Potential for Alteration in Bowel Elimination .assist resident with toileting every 2 hours and as needed, assist resident with cleansing perianal area after bowel movements, maintain resident dignity, praise continency .3/31/2023, **enhanced barrier precautions** open wound to buttock .3/12/25, Potential for infection: left buttock wound .Manifested by: drainage, redness . Of note: Physician progress note dated 10/28/24 states in part; he notes difficulty in obtaining a Roho cushion for offloading. We discussed the importance of offloading in regard to wound healing. Specifically, we discussed the benefits of obtaining a Roho cushion. It should be noted R19's care plan indicates R19 Roho was care planned beginning on 2/12/25. However, a progress note dated 1/9/25 states R19 was using a Roho on this visit. This is several months after a Roho was recommended by R19's physician. Additionally, R19's care plan states in part: .2/15/25, Care Plan Summary .R19 had a surgical procedure to close the chronic wound to his left buttock. The drain fell out and sutures were removed. The procedure was unsuccessful. He continues to have an open area, surgeon was notified. He sees wound care on a regular basis. He seen the surgeon again and R19 is to try to stay in bed as much as possible and stay off bottom. If the wound does not decrease in size surgeon wants to perform flap procedure . Progress notes in R19's Electronic Health Record include, in part: 1/21/24 - Wound on left buttock started 1/22/24 - Physician note - .He does have a history of Prostate Cancer, was started on radiation on November 29, 2023, again. A/P: 1. Hypertensive Heart Disease 2. Coronary Artery Disease 3. Diarrhea Secondary to Radiation . 2/9/24 - Care plan summary notes - .He is currently using a slide board for transfers. R19 states the slide board causes him pain and now he has shearing. He was seeing therapy for a different transfer method or slide board. Therapy states he did not like the other board and stopped going after 4 visits . Of note: there is no evidence that the facility completed risk vs benefits with R19 despite knowing that R19 did not want to try an alternative slide board or by declining participation in therapy. 2/17/24 - Physician note - .He is complaining of a lot of soreness on his bottom because of the diarrhea which has created a couple of wounds . 3/21/24 - Physician note - .We will need to find a solution to decrease friction from the sliding board as much as possible which appears to be contributing to slow healing of the wound . (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	5/16/24 - Physician note - .Completed radiation in January 2024 and as a consequence there was radiation proctitis with frequent diarrhea. He reports that the diarrhea has significantly improved since last week, however he is still dealing with a wound that seems to be consistent with an ulcer on the left buttock, likely from frequent friction on the sliding board . 6/4/2024 - Started wound clinic 8/13/24 - Wound clinic note - .nonhealing ulcer to left buttock, .5 x .5 x .3 - undermining from 10 o'clock to 11 o'clock approximately .3cm . 8/27/24 - Wound clinic note - .nonhealing ulcer to left buttock, .7 x .7 x .3 - undermining from 7 o'clock to 10 o'clock approximately .3cm . 9/10/24 - Wound clinic note - .nonhealing ulcer to left buttock, Thickness: full, .6 x .6 x .4 cm, undermining to circumference of wound . Patient Education: Continue using cushion in chair at all times. Reposition frequently. Lay on your side at night to relieve pressure. Patient states he has a pressure reducing mattress. 9/24/24 - Wound clinic note - .Wound is bigger .1 x .8 x .5, undermining to circumference of the wound . Mixture of granulation tissue and nongranular tissue .appearance of biofilm present . 10/7/24 - Wound clinic note - .chronic wound buttocks, 1 cm x .8 cm, undermining present . 10/28/24 - Wound clinic note - .History of Present Illness: .He developed multiple wounds of the buttocks approximately 6 months ago as a consequence of loose stools due to radiation for prostate cancer. All of the wounds have since resolved with the exception of a persistent wound of the left gluteal region .Procedure: Sharp debridement and partial delayed primary closure of wound, left buttock .Findings: 2x2x1cm ulceration of the left gluteal region with fibrous tissue about the base and undermining circumferentially. The fibrous tissue about the base was sharply debrided with partial primary closure of the wound over a Penrose drain . He notes difficulty obtaining a Roho cushion for offloading given he is currently in the process of obtaining a new chair. Also, noted today he is sitting on a folded towel underneath the wound of left buttock. States he has been doing this for some time as he feels that it alleviates some pressure and discomfort. Assessment and Plan .We discussed the importance of offloading in regard to wound healing. Specifically, we discussed the benefits of obtaining a Roho cushion and avoidance of placing a towel underneath the left buttock, as this may well be making the ulceration worse . Of note: there is no evidence that the facility completed risk vs. benefits with R19 despite knowing that R19 was using a rolled-up washcloth under his bottom while in his wheelchair. 11/1/24 - .has surgical wound left buttock, length .8cm, width 1cm, depth .5cm, drainage none, odor none, wound bed open, intact surrounding tissue .drain and sutures removed . (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	11/6/24 - Wound doctor note - .History of Present Illness: .chronic decubitus ulceration of the left buttock . The Penrose drain placed within the wound was noted to be dislodged by staff at his facility. This along with the suture for delayed primary closure was removed. He presents today at the request of facility staff due to concerns of worsening of the wound . Assessment and plan: The wound appears to be progressing well. We discussed the importance of continue to work on offloading specially I recommend a Roho cushion as he does spend 4 to 5 hours/day in his chair. We will attempt to arrange this for him. Of note: R19 is not currently using a Roho despite wound physician's recommendation for the use of a Roho cushion on 10/28/24. 12/4/24 - Wound doctor note - .Primary Diagnosis: Pressure Injury of left buttock, stage 3 .1 month status post debridement and partial delayed primary closure of a chronic decubitus ulceration of the left buttock .He occasionally places a towel under the left gluteal region during transport as this improves symptoms during transport . Assessment and plan: One month status post debridement and partial delayed closure of chronic decubitus ulceration of the left buttock, progressing well, significantly improved since debridement and delayed primary closure. 1/9/25 - Wound doctor note - .History of Present Illness: .chronic decubitus ulceration of the left buttock . he has been progressing well post procedurally. He occasionally places a towel under the left gluteal region during transport as this improves symptoms during transport. He is using a Roho cushion in his wheelchair. There is a 1 x 1 x 0.5 cm wound of the left gluteal region, increased in size from his previous visit. There is granulation tissue about the base of the wound. There is mild undermining of the wound circumferentially. Assessment and Plan: Wound is improved since partial delayed primary closure but has increased in size from his previous appointment. We discussed that we should continue to work on offloading, and avoidance of placing a towel underneath the wound during transport. He does have a Roho cushion which is excellent. Of note, although the physician discussed the avoidance of using the towel there is no evidence that the facility completed risk vs benefits with R19 despite knowing that R19 was using a rolled-up washcloth under his bottom while in his wheelchair. 1/22/25, Wound Clinic Assessment 1cm x 1cm x 0.4cm nonhealing ulcer to left buttock, full thickness. undermining entire circumference of wound, unable to measure due to pain. Granulation tissue 20% Slough 80%, distinct unattached wound border circumference of wound. Of note, R19's Medication Administration Record/Treatment Administration Record (MAR/TAR) for January shows the following entry added on 1/9/2025 and signed off through March 2025, Encourage repositioning and document refusals. *Ensure off-loading of left hip, avoid placing towel under left buttock when in w/c! Three times daily NOC AM PM 2/12/25 - .chronic wound to left buttock, 1cm x 1.2cm x .2cm, scant drainage, no odor, granulation tissue, intact, fragile - worsening, becoming larger . 2/12/25 - Wound doctor note - .Primary Diagnosis: Pressure Injury of left buttock, stage 3 . (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2/19/25 - Chronic nonhealing ulceration overlying the left ischial tuberosity. He did undergo primary closure of this wound on 11/4/24 in clinic. He initially responded well to this, but the wound has since recurred. He has been undergoing cares in the wound clinic without significant improvement. He notes some pain at the site, although this is fairly minimal. He notes no drainage from the wound. Of note, he was recently transition {sic} to an inflatable cushion on his wheelchair as opposed to the Roho cushion. There is a 1.1cm x 1.1cm x . 2cm wound of the left gluteal region, increased in size from his previous visit. There is granulation tissue about the base of the wound. There is mild undermining of the wound circumferentially. There is erythema and skin breakdown of the bilateral ischial tuberosities. He did undergo primary closure of the wound on 11/4/24, which initially resulted in resolution of this wound, with subsequent recurrence. We discussed that this is likely due to persistent trauma on the wound in his chair and potentially during patient transfer. We discussed that it be preferable for him to transition back to the Roho cushion as he was transitioned to an inflatable cushion approximately 2 weeks ago. Examination today is notable for PI and trauma to the skin overlying the bilateral ischial tuberosities. As this would be ongoing for some time, we discussed procedural options to address this. We discussed that we would likely proceed with advancement flap for definitive repair. However, we did discuss that this would require him to be out of the chair for at least 2 weeks, potentially longer. Alternatively, we discussed that we could avoid utilizing the chair for the next 2 to 3 weeks and assess his progress with this. We did discuss that the wound would likely demonstrate interval improvement with minimizing trauma to this area. He would like to try this option instead. Will plan on clinic follow-up in 3 weeks to assess his progress and need for advancement flap at this time. 2/26/25 - .per wound clinic, chronic denuded area (open area where the skin has been completely removed, exposing underlying tissue), left buttock, length 1.3cm x width 1cm, worsening, getting larger . 3/5/25 - .per wound clinic, chronic denuded area, left buttock, 1cm x 1cm x .2cm, improving, becoming larger . 3/5/25 - Wound clinic note Chronic nonhealing ulceration overlying the left ischial tuberosity. He did undergo primary closure of this wound on 11/4/24 in clinic. He initially responded well to this, but the wound has since recurred. He has been undergoing cares in the wound clinic without significant improvement. He notes persistent pain at the site. Previously we elected to transition back to the Roho cushion and minimizing time in his chair. He seems to have responded minimally to these interventions. And now is experiencing pain overlying the right ischial tuberosity. There is a 1 x 1 x .2cm wound of the left gluteal region, stable in size from his previous visit. There is granulation tissue about the base of the wound. There is mild undermining of the wound circumferentially. There is erythema (redness) and skin breakdown of the bilateral ischial tuberosities. There is now an additional superficial ulceration overlying the right ischial tuberosity . Assessment and Plan: Examination today is notable for trauma to the skin overlying the bilateral ischial tuberosities and now superficial ulceration overlying the right ischial tuberosity. The ulceration to the left ischial tuberosity is unchanged. With this, we discussed concerns in proceeding with the rotational flap closure, as despite interventions thus far, he continues to demonstrate trauma to this region. I am concerned that a rotational flap repair would fail for the same reasons. We discussed that it may be prudent to proceed with submission for Edify and/or Heliogen application to the wound, which may expedite wound healing. We discussed the continued importance of minimizing trauma to the skin of this region as well as minimizing time in his chair. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Of note: Despite the MD noting the importance of minimizing trauma to the buttocks and PI areas there is no evidence the facility provided alternative transfer methods besides the slide board to R19. Additionally, there is no evidence the facility discussed the risks of the slide board transfer, continued shearing making wound healing difficult, deterioration of the wound, or potential for infection. R19 presents with deterioration of his PI and now an additional PI to the right ischial tuberosity. 3/6/25 - .open area, appears to be shearing from sliding in bed or using slide board or both, right inner thigh - .5cm x .5cm x <.1cm, no drainage, no odor, wound bed sheared, surrounding tissue intact, fragile, dry . 3/11/25 - .chronic wound left buttock, 1 x 1.3 x .1cm, drainage heavy >75%, no odor, non-granular tissue, surrounding tissue intact, reddened, redness noted 7cm around wound . 3/11/25 - .right ischium shearing, length 1cm x width .6cm x .1cm, no odor, no drainage, non-granular tissue, intact . 3/12/25 - Staff from Sauk County Health Care Center called this AM with concerns over patient having increased drainage and redness to the left wound, also reports new wound to right leg. Infection Indicators: erythema (redness), increased drainage. Wound culture collected 3.12.25. Left ischial tuberosity full thickness, 1cm x 1.3cm x 0.1 cm. 100% nongranular tissue, denuded erythema. Stage 2 right inner thigh, healed. Wound culture results: moderate growth of beta hemolytic streptococcus. R19 was started on Cephalexin 500mg capsule by mouth three times a day for 7 days, beginning 3/13/25. 3/19/25 - .left buttock, .8 x .8 x .1cm, drainage light <25%, no odor, wound bed nonviable tissue 100%, surrounding tissue denuded, erythema . 3/19/25 - .shearing/friction from slide board/bed, right inner thigh, .3cm x .4cm x <.1cm, scant drainage, no odor, non-granular 100% . 3/26/25 - nurse note - .right thigh wound healed, Dr. applied EpiFix graft to left buttock wound .8 x 1 x .1cm . 3/26/25 - Change of Condition notes - .Wound nurse, orders from Dr. - new orders received and noted .right thigh wound healed - no dressing needed .left buttock wound measures .8cm x 1cm, graft applied - do not remove dressing for at least 5 days. Please call wound clinic if dressing needs to be changed before - resident updated and agrees to plan of care . On 3/26/25 at 3:53 PM, Surveyor interviewed LPN D (Licensed Practical Nurse) regarding R19's PI and if it has ever been staged. LPN D indicated it's not considered a pressure injury and has never been staged. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/26/25 at 4:14 PM, Surveyor interviewed LPN L at the wound clinic via phone and asked about R19's wound. She indicated it should be classified as a pressure injury, she thought when they started seeing him it was staged at stage 2. She stated, somewhere along the way, it got changed to non-healing chronic wound. LPN L stated R19 had an EpiFix graft done today, and dressing can't be removed for 5 days unless there is drainage. Surveyor asked LPN L about the infection and LPN L indicated they did a wound culture at the clinic on 3/12/25 due to increased redness around the wound. They swabbed it and culture came back showing an infection. On 3/27/25 at 8:29 AM, Surveyor interviewed RN E (Registered Nurse) about how wounds get classified in the facility. RN E stated the Wound Nurse classifies wounds. On 3/27/25 at 8:36 AM, Surveyor interviewed ADON I (Assistant Director of Nursing, also Wound Care Certified, facility wound nurse) regarding R19 and the staging of his wounds. ADON I stated if she felt a wound was related to pressure, it would be staged - only time wound is staged is if it's pressure. ADON I indicated she didn't feel R19's wound was pressure. She stated he first got the wound after radiation treatment when he had diarrhea. Surveyor asked why R19's PI wasn't on the matrix, ADON I indicated it's not on matrix because the facility does not consider R19's wound a pressure injury. ADON I stated the wound was caused by friction and shearing from R19's slide board and this continues and could be why it isn't healing. ADON I indicated R19 is getting therapy currently, they have tried 2 different slide boards - plastic and wood. ADON I stated R19 has not always been compliant with therapy in the past. ADON I stated she doesn't think R19's PI was ever staged. Surveyor asked if the facility completed a risk vs benefits with R19, regarding the use of the slide board, sitting up in the wheelchair and use of the Roho cushion. ADON I indicated she did, but she did not document this anywhere. Surveyor asked if it should be documented and ADON I stated yes. During a follow up interview with ADON I on 3/27/25 at 10:59 AM, Surveyor asked if ADON I was aware of R19 sitting on a towel or washcloth when in R19's w/c (wheelchair). ADON I indicated no, she wasn't aware of that. When asked if there should be anything between a Roho cushion and resident, she stated no. Surveyor asked ADON I if friction and shearing are components of pressure. ADON I stated yes, it can be. When asked about what standard of practice she is using to classify or stage wounds, ADON I stated she uses the book she received from wound care certification course WCEI (Wound Care Education Institute). Surveyor also asked what the facility does to prevent infection. ADON I stated, change dressing as ordered, cleaning wound, incontinence care, random audits - PPE (personal protection equipment) application/removal, hand hygiene - every other month, DON B (Director of Nursing) does the audits. On 3/27/25 at 10:41 AM, Surveyor interviewed R19 and asked if he is using a towel under his bottom when he is in his w/c. R19 stated no, he doesn't remember having a towel. He indicated he rolled up washcloths a couple times and put them on his bottom to relieve pressure in his wheelchair. He stated his doctor talked to him about not doing this, indicated the facility didn't. R19 stated his doctor wasn't happy about it. Of note, on 3/27/25 at 10:45 AM, Surveyor observed a rolled-up washcloth in R19's wheelchair while interviewing him. Surveyor also observed a stack of washcloths on his table. (continued on next page)

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

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/27/25 at 10:46 AM, Surveyor interviewed CNA J (Certified Nursing Assistant) who has worked at facility for 6 years. CNA J indicated she is aware R19 has a wound on his bottom, CNA J stated she cleans R19 up when R19 is incontinent. CNA J stated R19 likes to put washcloths in the peri area, and he might be propping them on his bottom. CNA J indicated she would advise him against it and stated she has talked to the nurse in the past about R19 sitting on washcloths. Surveyor asked CNA J how R19 transfers. CNA J stated R19 was using a slide board. Surveyor asked if they had tried other alternatives beside the slide board. CNA J stated not until now, now we are to use a Hoyer transfer. On 3/27/25 at 10:51 AM, Surveyor interviewed LPN G about R19 having a washcloth in his wheelchair. LPN G stated she knows R19 uses washcloths to wash hands after using his urinal. LPN G indicated she doesn't know about R19 putting a washcloth in his wheelchair. LPN G stated she has talked to R19 in the past about it but doesn't know about a risk vs benefits form. Surveyor asked if she ever discussed the concerns about using the slide board as a contributing factor to his PI. LPN G stated no, he has been using the slide board. On 3/27/25 at 3:31 PM, Surveyor Interviewed DON B (Director of Nursing), and ADON I and asked about the slide board being a contributing factor for R19's wounds. DON B and ADON I indicated the facility tried different slide boards, wood and plastic. They indicated maintenance sanded down a board to see if that would make one smoother, they thought maybe there was a rough spot on the slide board causing friction. Surveyor asked if any other interventions were attempted and they replied, he is working with therapy now, have tried supplements. DON B and ADON I stated R19 is now a Hoyer transfer, and he has refused Hoyer in the past. Surveyor asked if friction was a component to R19's pressure injuries. DON B and ADON I indicated no. Surveyor asked what they consider friction, they responded going against another surface, not pressure necessarily. Surveyor asked DON B and ADON I if friction could turn into pressure. DON B stated, Not for this resident. DON B stated R19 repositions himself all the time, they feel it is shearing and friction and don't consider the wound pressure. Surveyor asked DON B and ADON I if the wound physician note called the wound decubitus ulceration, why didn't facility call it that. They indicated the primary physician identified it as friction and shearing from diarrhea related to radiation. They stated he had so much diarrhea at first, impaired vascularity, radiation, was a smoker - feels that all components put together contributed. Surveyor asked about risk vs benefits being done regarding the use of the slide board, using a washcloth under his bottom in w/c, refusing therapy in the past, and continued use of the slide board. DON B stated she talked to R19 about these things. Surveyor asked if it was documented, and she stated she would have to check the documentation. DON B stated risk vs benefits should be documented. No documentation was provided by the facility for risk vs benefits. A risk and benefit was completed after surveyors exited the facility. On 3/31/25 at 10:40 AM, Surveyor interviewed WD K (Wound Doctor) via phone and asked about the staging and treatment of R19's PI. Surveyor asked WD K how he would classify R19's PI. WD K stated he would classify it as a pressure injury, stage 3. He stated it's a decubitus ulceration; there is subcutaneous tissue. He added it would still be a stage 3 pressure injury now. Surveyor asked WD K if the facility should have considered alternatives for the slide board. WD K stated it's not for him to say but it likely is a causative factor. WD K told Surveyor he's glad he uses a Hoyer now. Surveyor asked about the primary closure procedure completed on 10/28/24. WD K stated he felt it was needed because the wound was chronic, wasn't resolving, and was causing resident discomfort. Surveyor asked about the EpiFix graft done on 3/26/25. WD K indicated he wanted to do the graft as the wound had deteriorated and this was an effort to help the PI heal. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility identified the use of a slide board transfer as a causative factor in contributing to R19's PI development. Despite this knowledge R19 continued to use the slide board. There is no evidence the facility provided R19 with the risks for continuing the use of slide board transfers or using rolled-up washcloths to relieve pressure on his bottom while in wheelchair. The facility did not identify R19's left gluteal pressure injury as a pressure injury (PI) or stage the PI despite the wound physician identifying it as a stage 3 pressure injury or decubitus ulceration on multiple progress notes. R19 developed two facility-acquired pressure injuries. R19's left ischial tuberosity deteriorated and became infected requiring a EpiFix graft to promote healing. The facility's failure to use an alternative transfer method to the slide board and failure to provide resident with risk vs. benefits of continued use of the slide board led to serious harm and created a finding of immediate jeopardy. The facility removed the jeopardy on 3/31/25 when it completed the following: R19 was educated Friday, March 28 on Risks vs Benefits regarding use of the slide board and placing barrier on top of pressure relieving device which decreases effectiveness. Resident was consistently refusing interventions including, but not limited to, nutritional supplements, attending scheduled appointments regularly, participating in therapy and following recommendations of using Hoyer Lift instead of the slide board. This was also included in his Risks vs Benefits education. Nursing staff was educated beginning 3/31/25 and/or prior to their next shift to be worked regarding: Prevention of Pressure Injury, including: A. Pressure Points, Shearing, Friction and Proper Positioning. B. What to look for regarding what interventions are working and wha [TRUNCATED]

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41788 Based on observation, interview, and record review, the facility did not ensure a resident with a catheter receives appropriate treatment and services to prevent urinary tract infections for 1 of 3 residents (R25) reviewed for catheter care out of total sample of 17. Staff did not perform appropriate hand hygiene per Standards of Practice while providing catheter care. Evidenced by: The facility policy entitled. Hand Washing, dated 3/19/24, states, in part: . Purpose: -To cleanse hands to prevent the spread of potentially deadly infections -To provide a clean and healthy environment for residents, staff, and visitors -To reduce the risk to the healthcare provider of colonization or infections acquired from a resident Hand hygiene continues to be the primary means of preventing the transmission of infection. Policy: It is the policy of this facility that hand hygiene (HH) (e.g. hand washing and/or Alcohol-based hand rub (ABHR), also known as Alcohol-based hand sanitizer (ABHS), is to be performed consistent with accepted standards of practice in order to reduce the potential of the spread of pathogens. Procedures: Hands shall be washed . 2. Before and after any personal body function, such as eating, blowing or wiping nose, coughing, sneezing, smoking, using bathroom, combing hair. 3. Before and after direct contact with residents . 5. After handling waste materials, bedpans, feces, specimens, secretions, drainage, or blood . R25 was admitted to the facility on [DATE], and has diagnoses that include Extended spectrum beta lactamase (ESBL) resistance (an enzyme produced by some bacteria that makes them resistant to certain antibiotics, including penicillins and some cephalosporins, making them harder to treat), retention of urine (difficulty urinating and completely emptying the bladder), and obstructive and reflux uropathy (a condition where urine flow is blocked or backs up, potentially damaging the kidneys). (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R25's Quarterly Minimum Data Set Assessment, dated 1/8/25, shows R25 has a Brief Interview of Mental Status (BIMS) score of 15 indicating R25 is cognitively intact. R25's Care Plan, dated 2/2/22, states, in part: . Problem: 2/02/22 Altered Urine Pattern R/T (related to) Diabetes, Chronic Foley Catheter .Nurse Aide: . Provide catheter care with cares and as needed .Special Approaches: **enhanced barrier precautions**(an infection control strategy that uses gloves and gowns during high-contact resident care to reduce the spread of multidrug-resistant organisms (MDROS)) . Problem: 2/02/22 Infection: Enhanced barrier precautions** Nurse Aide- Use good hand washing techniques before and after cares, Keep area clean and dry . R25's Medication Administration Record for March 2025 shows: -Entry Date- 2/02/22 Administer Foley catheter care BID (twice a day) AM at bedtime AM CNA (certified nursing assistant) PM CNA . R25's Physician Orders, dated 3/17/25, states, in part: . Administer Foley catheter care bid AM at bedtime AM CNA PM CNA . Change indwelling foley catheter as needed when encrusted or obstructed. Reason for Foley- Neurogenic bladder **extension tubing must be placed ** SIZE OF CATHETER Other: 18 FR (French) 10 mL (milliliter) balloon . On 3/26/25, at 11:08 AM, Surveyor observed CNA H perform catheter care on R25. CNA H did not change gloves or perform hand hygiene after providing catheter care or before retrieving R25's gait belt off R25's walker. CNA H then wrapped the gait belt around R25. CNA H then proceeded to assist R25 to a standing position from the toilet, CNA H pulled R25's clean brief and pants up. CNA H then untucked R25's shirt and walked R25 out of bathroom to his electric wheelchair, while wearing the same gloves used to perform peri care and catheter care. On 3/26/25, at 11:15 AM, Surveyor interviewed CNA H and asked when hand hygiene should be performed. CNA H indicated anytime gloves are removed, after going from peri cares to the back side of residents, when dirty, and from going from clean to dirty areas. Surveyor asked if hand hygiene and gloves should have been changed after catheter care was completed and touching R25's gait belt and clothing and CNA H indicated yes. Surveyor asked if CNA H performed hand hygiene at that time and CNA H indicated she did not and should have. On 3/26/25, at 11:15 AM, Surveyor interviewed DON B (Director of Nursing) and informed her of observation of catheter care. Surveyor asked DON B if she would expect hand hygiene to be performed in between catheter care and applying gait belt, pulling up brief and pants and walking R25 to his electric wheelchair. DON B indicated yes, hand hygiene and glove change should have been performed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41788 Based on observation, interview, and record review, the facility did not ensure that it was free of medication error rates of 5% or greater. There were 2 errors in 29 opportunities that affected 2 out of 7 residents (R30 & R9) included in the medication pass task, which resulted in an error rate of 6.9%. R30 did not receive her ordered senna at the ordered time. R9 did not receive her ordered aspirin at the ordered time. Evidenced by: The facility policy entitled, Medication Pass, dated 2/2016, states, in part: .Policy: It is the policy of the [Facility name] that medications prescribed by the Physician will be administered accurately and timely. Procedure: .2. Read and compare the label on the drug with the MAR (Medication Administration Record) at least three (3) times- before, during and after preparing the drug .16. Be sure that you have the- A. Right Drug B. Right Dose C. Right Route D. Right Time E. Right Resident . Example 1: R30 was admitted to the facility on [DATE] and has diagnoses that include hemiplegia following nontraumatic intracerebral hemorrhage affecting left nondominant side (paralysis or weakness on one side of the body) and hypertensive heart disease without heart failure (heart issues that develop due to long-term high blood pressure). R30's Quarterly Minimum Data Set (MDS) Assessment, dated 9/24/24, shows that R30 has a Brief Interview of Mental Status (BIMS) score of 8 indicating R30 has moderate cognitive impairment. R30's Physician Orders, dated 3/25, states, in part: .3/26/25 Drug: Senna-Docusate Sodium 8.6mg (milligrams)-50mg Tablet by mouth Take 1 daily AM for constipation . R30's Medication Administration Record (MAR) for March 2025 shows: Drug: Senna-Docusate Sodium 8.6mg-50mg Tablet by mouth Take (1) daily AM For: Constipation . (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Drug: Anorco Ellipta 62.5 mcg (micrograms)/ACT-25 mcg/ACT Aerosol Powder Breath Activated Inhalation Take (1) puff daily AM For: Restrictive lung diagnosis. Drug: [Protonix] Pantoprazole Sodium 40 mg Tablet Delayed Release by mouth Take (1) daily AM For: Gastroesophageal Reflux Disease (GERD) Drug: [Keppra] levetiracetam 250 mg Tablet by mouth Take (1) BID (twice a day) AM at bedtime. For: Seizure first date: 7/24/24 Drug: Artificial Tears . 0.5%-0.6% Solution to eye(s) (both) Take (1) TID (three times a day) AM PM at bedtime. For: Dry eyes Drug: Cetirizine . 10 mg Tablet by mouth Take (1) daily AM For: Pruritis (itching) first date: 10/03/24 Drug: metformin . 500 mg Tablet by mouth bid AM PM First Date: 3/6/25 For: Type 2 Diabetes Mellitus Drug: Gabapentin 100 mg capsule by mouth Take (1) bid AM Midday For: Neuropathic Pain Drug: Vitamin D .1.25 MG (5000 UT) Capsule by mouth Take (1) 1 x week Tuesday AM For Vit D deficiency . On 3/25/25 at 8:05 AM, Surveyor observed LPN C (Licensed Practical Nurse) administer scheduled AM medications which did not include the scheduled senna docusate sodium as it is ordered. On 3/25/25 at 9:30 AM, Surveyor reconciled medications that were administered to R30 to R30's MAR to find the senna docusate sodium was signed out that it was given. Surveyor had observed the medication pass and senna docusate sodium was not administered. On 3/25/25 at 9:47 AM, Surveyor interviewed LPN C and asked about the senna docusate sodium being signed out as if it was given. LPN C indicated she thought she had given it. Surveyor informed LPN C showed Surveyor's documentation it had not been administered. Surveyor asked LPN C if that was a medication error and LPN C indicated she would just give R30 the senna at lunch time. Example 2: R9 was admitted to the facility on [DATE] and has diagnoses that include hypertensive heart and kidney disease with heart failure (occurs when high blood pressure damages the kidneys and heart, leading to complications like heart failure and kidney failure). R9's Quarterly MDS Assessment, dated 2/8/25, shows that R9 has a BIMS score of 11 indicating R9 is mildly impaired cognitively. R9's Physicians Orders, dated 3/2025, states, in part: . . Drug: Aspirin EC (enteric coated) 81 mg Tablet Delayed Release by mouth Take (1) daily at bedtime. For: Anticoagulant Therapy . (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R9's March MAR shows: Drug: [acetaminophen 8 hour] Acetaminophen ER (extended release) 650 mg Tablet Extended Release by mouth TID Early AM Midday at bedtime. Not to exceed 3GM(GRAMS)/24 hour. For: Pain. Drug: Carvedilol 6.25 mg Tablet by mouth BID with meals Breakfast Supper For: Hypertension. Drug: Glimepiride 4 mg Tablet by mouth Take (1) bid with meals Breakfast Supper. For: Type 2 Diabetes Mellitus. Drug: Docusate Sodium 100 mg Capsule by mouth Take (1) bid AM PM For: Bowel Aid. Drug: Sertraline . 50 mg Tablet by mouth Take (1) daily PM For: Depression/anxiety . On 3/25/25 at 4:03 PM, Surveyor observed LPN D administer medication to R9 which included docusate sodium, aspirin, sertraline, carvedilol and glimepiride. (of note: R9's aspirin is ordered at bedtime) On 3/25/25 at 4:21 PM, Surveyor interviewed LPN D and asked when the aspirin is to be administered. LPN D indicated it should have been given after supper as a bedtime medication as ordered. LPN D indicated she had noticed the aspirin was for bedtime but had already put it in the medication cup and just decided to give it. Surveyor asked if this is a medication error and LPN D indicated yes, the aspirin should have been administered at bedtime. Surveyor asked what the 5 rights are that are used for medication pass and LPN D indicated right med, right patient, right time, right route, and right dose. Surveyor asked LPN D when medications are ordered to administer at bedtime, what time does facility use for bedtime. LPN D indicated bedtime scheduled medications get administered after supper until 10:00 PM. On 3/26/25 at 10:45 AM, Surveyor interviewed DON B (Director of Nursing) and informed her of the medication observation errors. DON B indicated senna and aspirin being administered at the wrong times are medication errors. DON B indicated she would expect medications to be administered at ordered times.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 41788 Based on observation, interview, and record review, the facility did not assure drugs and biologicals used in the facility were stored and labeled in accordance with currently accepted professional practices and include the expiration date when applicable for 1 of 2 medication rooms and 2 of 5 medication carts reviewed for compliance. Surveyor observed the following: -R25's PRN (as needed) Loperamide (27 capsules) expired 12/24. -R19's PRN Loperamide (4 capsules) expired 12/24. -R6's escitalopram (1 tablet) card expired 9/24. -3 boxes of blood glucose control solutions expired (7/27/23 & 3/1/25). -R9's Naproxen (7 tablets) PRN card expired 11/24. -6 stock insulin pens were expired: -1 Semglee expired 6/24. -2 Tresiba expired 12/31/23 & 11/30/24. -3 Basaglar expired 8/17/24 and 2 on 4/04/24. -Stock supply of Promethazine suppositories (6 suppositories) expired 10/24. Evidenced by: The facility policy entitled, Medication Storage Policy, undated, states, in part: .Policy: The facility shall store all drugs and biologicals in a safe, secure, and orderly manner. Procedure: . D. The facility shall not use discontinued, outdated or deteriorated drugs or biologicals. All drugs shall be returned to the dispensing pharmacy or destroyed per state regulation . Example 1: (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/25/25 at 1:58 PM, Surveyor observed cart #3 with LPN C (Licensed Practical Nurse). Surveyor found R25's PRN card of loperamide 2 mg (milligrams) 27 capsules with an expiration date of 12/24. Surveyor found R19's PRN card of loperamide 2 mg, 4 capsules with an expiration date of 12/24. Surveyor found R6's escitalopram 10 mg cycle card with 1 tablet expired on 9/24. Surveyor found 2 boxes of blood glucose control solutions expired on 7/27/23 & 3/1/25. On 3/25/25 at 2:17 PM, Surveyor interviewed LPN C and asked what the expiration dates were on the two boxes of blood glucose control solutions. LPN C indicated 7/27/23 and 3/1/25. LPN C indicated both boxes were expired and should not be in circulation and removed from the cart. Surveyor asked LPN C what the expiration dates were on R25 and R19's PRN loperamide cards and R6's escitalopram card. LPN C indicated by looking at it she was not sure, and LPN C indicated she needed to call the pharmacy. LPN C returned and indicated the date on the card was when the prescription expired not the medication. LPN C indicated there is no expiration dates on the cards. Surveyor asked how one would know when the medications expire then, and LPN C indicated you would not know as the medications come out of one big stock bottle that has an expiration date on, but the cards do not and should. LPN C indicated the three cards are being returned to the pharmacy. Example 2: On 3/25/25 at 2:33 PM, Surveyor observed medication cart #2 and medication storage room with RN E (Registered Nurse) and found R9's PRN card of Naproxen 500 mg with 7 tablets expired on 11/24. Surveyor found 6 stock insulin pens expired: one Semglee insulin glargine injection 100 units/mL (milliliter) expired on 6/24, two Tresiba insulin degludec injection pens 200 units/mL expired on 12/31/24 & 11/30/24, and three Basaglar insulin glargine injection pens 100 units/mL expired on 8/17/24, 4/4/24, and 4/4/24. Surveyor found a stock box of Promethazine 25 mg suppositories- 6 suppositories expired on 10/24 and a box of blood glucose control solution expired on 3/1/25. On 3/25/25 at 3:02 PM, Surveyor interviewed RN E and asked what the expiration date is on the medication card for R9. RN E called the pharmacy and found the date on the bottom right corner of the pharmacy label is the expiration date and the upper date is when the pharmacy filled the card. RN E confirmed R9's Naproxen expired on 11/24, and the box of Promethazine suppositories expired on 10/24. RN E indicated the box of blood glucose control solution expired on 3/1/25. Surveyor asked RN E if the 6 stock insulin pens were expired and RN E phoned pharmacy back. Surveyor spoke with PH F (pharmacist) who indicated the Semglee pen expired on 6/24 the manufacturer' date, Tresiba pens expired on 12/31/24 and 11/30/24, the manufacturer's date, and the three Basaglar pens expired on 8/17/24, 4/4/24, and 4/4/24, the manufacturer's date. RN E indicated the expired medications should not be in circulation and removed them. On 3/26/25 at 10:45 AM, Surveyor interviewed DON B (Director of Nursing) and informed DON B of the expired medications: R25's PRN (as needed) Loperamide (27 capsules) expired 12/24, R19's PRN Loperamide (4 capsules) expired 12/24, R6's escitalopram (1 tablet) card expired 9/24, 3 boxes of blood glucose control solutions expired (1-7/27/23 & 2-3/1/25), R9's Naproxen (7 tablets) PRN card expired 11/24, 6 stock insulin pens were expired (1 Semglee expired 6/24. 2 Tresiba expired 12/31/23 & 11/30/24. 3 Basaglar expired 8/17/24 and 2 on 4/4/24) and the stock supply of Promethazine suppositories (6 suppositories) expired 10/24. DON B indicated PH F had phoned her regarding the expired medications found and the expired medications should not be in circulation. DON B indicated her expectation is for the staff to check and know where the expiration dates are on medications administered and education is in progress to all nurses since this was brought to DON B's attention.