STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525304	A. Building B. Wing	07/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Shore Healthcare at Marshfield	814 W 14th St Marshfield, WI 54449

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure a Minimum Data Set (MDS) assessment was accurate for 1 resident (R) (R1) of 1 sampled resident.R1 was admitted to the facility with a surgical incision that was not represented to R1's admission MDS assessment. R1 also had a stage 3 pressure injury that was not represented on R1's Discharge MDS assessment. Findings include: The facility's Conducting an Accurate Resident Assessment policy, dated 4/28/25, indicates: The purpose of this policy is to assure that all residents receive an accurate assessment, reflective of the resident's status at the time of the assessment…3. The appropriate, qualified health professional will correctly document the resident’s medical, functional, and psychosocial problems and identified strengths to maintain or improve medical status, functional abilities, and psychosocial status. On 7/7/25, Surveyor reviewed R1’s medical record. R1 was admitted to the facility on [DATE] and had diagnoses including encounter for orthopedic aftercare (post-surgical incision to lower back), diabetes, heart failure, chronic kidney disease, and obstructive sleep apnea. R1's admission MDS assessment, dated 6/18/25, had a Brief Interview for Mental Status (BIMS) score of 9 out of 15 which indicated R1 had moderately impaired cognition. The MDS assessment indicated R1 was at risk for pressure injury but did not have a pressure injury, did not have pressure reducing devices for bed or chair, and was not on a turning/repositioning program. The MDS assessment also indicated R1 did not have any surgical wounds, did not receive surgical wound care, and needed moderate assistance with rolling left and right and going from a sitting to lying position. R1 had an order, dated 6/12/25, to assess the lumbar spine incision twice daily and update neurosurgery for wound dehiscence, drainage, streaking, or a temperature greater than 101 degrees Fahrenheit. R1 also had an order, dated 6/20/25, to paint the low back incision with Betadine, cover with an abdominal (ABD) pad, and secure with paper tape twice daily. A wound clinic visit note, dated 6/20/25, indicated R1 had a stage 3 sacral pressure injury that measured 3.0 cm (length) x 1.3 cm (width) x 0.2 cm (depth) with a small amount of exudate. A Discharge MDS assessment, dated 6/24/25, indicated R1 did not have any unhealed pressure injuries. On 7/7/25 at approximately 12:45 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated the surgical incision should have been identified on R1's admission MDS assessment. (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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/7/25 at 1:01 PM, Surveyor interviewed MDS Registered Nurse (MDSRN)-L who confirmed the surgical incision should have been identified on R1's admission MDS assessment and the pressure injury should have been identified on R1's Discharge MDS assessment. On 7/7/25 at 2:40 PM, Wound Clinic RN (WCRN)-H verified R1 was diagnosed with a stage 3 pressure injury during a wound clinic visit on 6/20/25.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure a complete baseline care plan was developed within 48 hours of admission for 1 resident (R) (R1) of 1 sampled resident.R1 had a surgical incision and was at risk for pressure injury upon admission. The facility did not develop a baseline care plan that indicated R1 had impaired skin integrity or included interventions for treatment and prevention. Findings include: The facility's Baseline Care Plan policy, revised 9/22/22, indicates: The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident…b. Including the minimum healthcare information necessary to properly care for a resident including, but not limited to: ii. Physician orders…2…b. Interventions shall be initiated that address the resident’s current needs including: i. Any health and safety concerns to prevent decline or injury, such as elopement, fall, or pressure injury risk…3. A supervising nurse or Minimum Data Set (MDS) nurse/designee shall verify within 48 hours that a baseline care plan has been developed. 4…c. Any services and treatments to be administered by the facility and personnel acting on behalf of the facility… On 7/7/25, Surveyor reviewed R1’s medical record. R1 was admitted to the facility on [DATE] and had diagnoses including encounter for orthopedic aftercare (post-surgical incision to lower back), diabetes, heart failure, and chronic kidney disease. R1's admission Minimum Data Set (MDS) assessment, dated 6/18/25, had a Brief Interview for Mental Status (BIMS) score of 9 out of 15 which indicated R1 had moderately impaired cognition. The MDS assessment also indicated R1 was at risk for pressure injuries but did not indicate R1 had pressure reducing interventions for bed or chair or was on a turning/repositioning program. In addition, the MDS assessment indicated R1 had moisture-associated skin damage (MASD). R1 had an activated Power of Attorney for Healthcare (POAHC) who assisted with medical decisions. admission orders, dated 6/12/25, indicated R1 had a surgical incision and included an order to assess R1's lumbar spine incision twice daily and update neurosurgery for wound dehiscence, drainage, streaking, or temperature greater than 101 degrees Fahrenheit (F). A skin assessment, completed during R1's admission assessment on 6/12/25, indicated R1 had a surgical incision and macerated area on the left inner buttock that measured 0.1 centimeters (cm) x 0.1 cm. Braden Scale Assessments (used to assess pressure injury risk), completed on 6/12/25 and 6/18/25, indicated R1 was at mild risk for developing pressure injuries. A weekly skin assessment, dated 6/17/25, indicated R1 had an open area on the coccyx, blanchable redness on the buttocks, a surgical incision on the spine with redness, and scattered bruises on the body. R1's medical record indicated R1 was admitted to the hospital on [DATE]. Hospital discharge paperwork, dated 6/17/25, indicated R1 had a decubitus ulcer. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A wound clinic note, dated 6/20/25, indicated R1 had a stage 3 (a deep wound that has gone through the skin and into the fat layer) pressure injury on the sacral region. On 7/7/25 at approximately 9:05 AM, Surveyor reviewed R1’s plan of care (dated 6/12/25) which did not indicate R1 was at risk for or had a pressure injury; did not indicate R1 had MASD; did not indicate R1 had a surgical incision; and did not contain any corresponding interventions. R1's plan of care also did not indicate R1 had impaired skin integrity. The facility updated R1's plan of care on 6/24/25 (which was R1’s last day in the facility) to indicate R1 had a surgical wound infection with interventions to administer medications as ordered, encourage R1 to use clean hygiene techniques to avoid cross-contamination, monitor for side effects from antibiotic therapy and report to physician, monitor lab work and report results to physician, and report to physician worsening signs/symptoms of infection, lack of infection, or lack of improvement for treatment. An additional revision on 6/24/25 indicated R1 had bowel/bladder incontinence, required assistance with toileting. and had a goal to remain free from skin breakdown due to incontinence. Interventions included to monitor and document intake and output, monitor for signs/symptoms of urinary retention, and monitor/document for signs/symptoms of urinary tract infection (UTI). On 7/7/25 at 1:01 PM, Surveyor interviewed MDS Registered Nurse (MDSRN)-L who indicated anything listed in the skin section of a resident's MDS assessment is added to the resident's plan of care by whoever completes the assessment. MDSRN-L indicated R1's surgical incision should have been on the admission MDS assessment and included in R1’s plan of care.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not provide the necessary care and services to prevent the development of pressure injuries and/or promote healing for 1 resident (R) (R1) of 2 sampled residents. R1 developed a stage 3 pressure injury on the sacrum. The facility did not implement interventions to prevent the pressure injury from developing and did not monitor the pressure injury after it was identified. Findings include: The facility's Pressure Injuries and Non-Pressure Injuries policy indicates: This center will complete a comprehensive assessment to identify risk factors for the development of pressure injuries and put in place measures intended to achieve the goal of prevention of pressure injuries .For those residents admitted with, or who subsequently develop a pressure injury or impaired skin integrity, they will receive care, treatment, and services that seek to promote healing, prevent infection, and prevent further development of pressure injuries/impaired skin integrity .Stage 3 pressure injury: 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 . Moisture-associated skin damage (MASD): Inflammation of the skin and erosion from prolonged exposure to moisture and its contents. Common sources of moisture include urine and stool, perspiration, wound exudate .Upon admission: a. A head-to-toe body evaluation .ii. If non-pressure: Initiate the Non-Pressure Injury Tracker UDA (User-Defined Assessment) .B. Complete the Braden Scale to assess risk of development of a pressure injury .i. Upon admission/re-admission .C. Initiate the baseline plan of care related to current skin status and skin risk level. When determining skin risk status and appropriate interventions, consider the following: i. Braden Scale Score ii. Co-morbid conditions .diabetes mellitus .x. Exposure of skin to urinary and fecal incontinence .2. Weekly: a. Complete a head-to-toe skin check and document findings on the Skin Review .If new areas are present: Notify MD .iii. Initiate treatment per order .v. Update plan of care .B. Assess current wounds at least every seven days .A comprehensive skin integrity care plan is based on resident history, review of the Skin Assessment, Braden Scale .Consider the areas of risk, as well as overall risk assessment score of the Braden Scale .1. Develop interventions based on subsets of Braden Scale that may include: Sensory perception .moisture .activity .mobility .Develop turning/repositioning schedule based on resident's needs and risk factors .2. Develop interventions based on individual risk factors .The care plan should be updated to reflect the resident's choice and what interventions will be in place to minimize the risk to the resident .On 7/7/25, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including encounter for orthopedic aftercare (post-surgical incision to lower back), diabetes, heart failure, chronic kidney disease, and obstructive sleep apnea. R1 had an activated Power of Attorney for Healthcare (POAHC) who assisted with medical decisions. R1's admission Minimum Data Set (MDS) assessment, dated 6/18/25, had a Brief Interview for Mental Status (BIMS) score of 9 out of 15 which indicated R1 had moderately impaired cognition. The MDS assessment indicated R1 was at risk for pressure injuries but did not have a pressure injury, did not not have a pressure reducing device in bed or chair, was not on a turning/repositioning program, and required moderate assistance with rolling left and right and going from a sitting to a lying position. The MDS also indicated R1 had moisture-associated skin damage (MASD) but did not have any surgical wounds and did not receive surgical wound care. R1 had an activated Power of Attorney for Healthcare (POAHC). R1 was currently hospitalized for a surgical incision infection.An admission Assessment, dated 6/12/25, indicated R1 had a macerated area that measured 0.1 centimeters (cm) x 0.1 cm on the left inner buttock.A Braden Scale (skin integrity impairment risk), completed upon admission on [DATE], indicated R1 was at risk for impaired skin integrity.A care plan, dated 6/13/25, indicated R1 had limited mobility and needed the assistance of 1 staff with bed mobility.A baseline care plan, initiated 6/13/25 with revisions on 6/18/25, did not indicate R1 was at risk for skin impairment or contain skin impairment focus area. The baseline care plan also did not indicate interventions were implemented to prevent a pressure injury or prevent further injury after a stage 3 pressure injury was identified on 6/20/25.A non-pressure weekly tracker, dated 6/13/25, indicated R1 was admitted to the facility with a surgical wound on the lower back. No other wounds or MASD were identified.A hospital discharge record, dated 6/17/25, indicated R1 had a diagnosis of decubitus ulcer and an infectious disease workup showed leukocytosis and elevated inflammatory markers likely from underlying cellulitis around the sacral ulcer and contribution from postsurgical changes.A weekly skin assessment, dated 6/17/25, indicated R1 had an open area on the coccyx, blanchable redness to the buttocks, and a surgical incision on the spine with redness around the

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview and record review, the facility did not assess the risk for entrapment, review the risks and benefits, and obtain consent for the use of side rails for 1 resident (R) (R2) of 3 sampled residents. R2's bed contained side rails. The facility did not complete an assessment or obtain consent for side rails from R2's Power of Attorney (POA).Findings include: The facility's Proper Use of Side Rails policy, revised 9/23/22, indicates: .1. In conjunction with the review of a resident's comprehensive assessment, a side rail assessment will be completed in the electronic medical record. 2. The facility will attempt to use alternatives prior to using side/bed rails. Consider referral to therapy for bed mobility assessment .3b. Assess the resident for risks of entrapment and other risks associated with the use of side/bed rails .3c. i. If rail is determined to meet the definition of a restraint, obtain informed consent from the resident or the resident representative and physician order prior to installation/use.On 7/7/25, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] and had diagnoses including encounter for other orthopedic after care, vascular dementia, insomnia, use of anticoagulants, weakness, reduced mobility, and rheumatoid arthritis. R2's Minimum Data Set (MDS) assessment, dated 5/15/25, had a Brief Interview for Mental Status (BIMS) score of 12 out 15 which indicated R2 had moderately impaired cognition. R2 had an activated POA.On 7/7/25 at 10:03 AM, Surveyor interviewed R2 who was in a wheelchair in R2's room. Surveyor observed side rails on R2's bed. When asked about the care that R2 received, R2 stated R2 could not remember because R2 had dementia.Surveyor noted R2's medical record did not contain an assessment or consent from R2's POA for the use of side rails.On 7/7/25, Surveyor requested an assessment and consent for side rail use from Nursing Home Administrator (NHA)-A. On 7/7/25 at 12:00 PM, NHA-A confirmed the facility did not have an assessment or consent from R2's POA for the use of side rails on R2's bed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, staff interview, and record review, the facility did not establish and maintain an infection prevention and control program designed to help prevent the development and transmission of communicable disease and infection for 1 resident (R) (R8) of 1 resident observed during the provision of care.During the provision of care for R8, Certified Nursing Assistant (CNA)-E did not remove soiled gloves after incontinence care and did not wash or sanitize hands before touching R8 and objects in R8's room. Findings include:The facility's Hand Hygiene Policy, revised 11/02/22, indicates: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. Hand hygiene is a general term for cleaning your hands by handwashing with soap and water or the use of an antiseptic hand rub, also known as alcohol-based hand rub (ABHR). Hand hygiene is indicated and will be performed under the conditions listed in the hand hygiene table which include: Before applying and after removing personal protective equipment (PPE) including gloves; Before and after handling clean or soiled dressings, linens .; After handling items potentially contaminated with blood, body fluids, secretions, or excretions; When during resident care, moving from a contaminated body site to a clean body site; After assistance with personal body functions (e.g., elimination, hair grooming, smoking).On 7/7/25 at 3:14 PM, Surveyor observed cares for R8. Prior to cares, CNA-D and CNA-E completed hand hygiene and donned gloves. CNA-D unfastened R8's brief and pulled the brief down between R8's legs. Surveyor noted R8 was incontinent of urine. CNA-E provided peri-care with soap and water and then removed gloves. Without completing hand hygiene and donning clean gloves, CNA-E assisted R8 on R8's right side by holding R8's legs and back and picked up a tube of barrier cream. CNA-E did not complete hand hygiene until Surveyor inquired about hand hygiene. On 7/7/25 at 3:25 PM, Surveyor interviewed CNA-E who verified CNA-E did not complete hand hygiene after providing peri-care and removing gloves. CNA-E also verified CNA-E touched R8's legs, back, and tube of barrier cream with uncleansed hands.On 7/7/25 at 5:00 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated CNA-E should have completed hand hygiene and donned clean gloves after peri-care and before touching R8 or items in R8's room.