

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525375	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/18/2025
NAME OF PROVIDER OR SUPPLIER Hebron Oaks		STREET ADDRESS, CITY, STATE, ZIP CODE 510 Genomic Drive Madison, WI 53719	

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)
<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36192</p> <p>Based on observation, interview, and record review, the facility did not ensure each resident receives cares, consistent with professional standards of practice to promote healing, prevent infection, and prevent new injuries from developing for 2 of 3 residents (R1 & R3) reviewed with pressure injuries or at risk for developing pressure injuries.</p> <p>R1 was admitted on [DATE], without a pressure injury. R1 developed three pressure injuries - two identified as Deep Tissue Injuries (DTIs; a type of pressure injury that occurs when prolonged pressure or shear forces damage the underlying soft tissues, such as muscle, fat, and tendons) and one Unstageable (a full thickness wound where the base of the injury is obscured by a layer of dead tissue called slough or eschar). R1 did not have all weekly wound assessments completed, wound vac treatments were not completely correctly, robust pressure injury preventions were not implemented until after development of the pressure injuries, R1 and wound deterioration occurred. When interviewed in February 2025, R1 stated, What I've had to live with since (the development of the PI's) has not been a pleasant experience. I wish it would never have happened.</p> <p>R3 admitted to the facility with a stage 4 pressure injury (a full thickness wound that exposes bone, muscle, or tendon) with osteomyelitis (a bone infection characterized by inflammation of the bone tissue). The facility did not complete weekly assessments and ensure that skin interventions were followed per standards of practice. R3's developed multiple wounds on his lower extremities and R3's sacral wound deteriorated and became infected.</p> <p>The facility's failure to ensure R1 and R3 received the necessary treatment and services to promote healing, prevent infection, and prevent new pressure ulcers from developing created a finding of immediate jeopardy that began on 10/31/24. Surveyor notified NHA A (Nursing Home Administrator) of the immediate jeopardy on 2/6/25 at 2:05 PM. The immediate jeopardy was removed on 2/10/25; however, the deficient practice continues at a scope/severity of D (potential for more than minimal harm/isolated) as the facility continues to implement its action plan.</p> <p>This is evidenced by:</p> <p>(continued on next page)</p>

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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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The facility policy Skin Injury Prevention and Management Program Guidelines, dated 10/17/23, indicates, in part: Residents admitted to Oakwood Village without pressure injuries will not develop pressure injuries unless the resident's clinical condition demonstrates that it was clinically unavoidable. Staff will provide care and services to: Promote the prevention of pressure injury development. Promote the healing of pressure injuries that are present (including prevention of infection to the extent possible). Prevent the development of additional pressure injuries. Prevent the reoccurrence of healed pressure injuries.</p> <p>General Information: Pressure injuries occur when tissue is compressed between a bony prominence and an external surface. In addition to pressure, shear force and friction are important contributors to pressure injury development. Skin and soft tissue changes associated with aging, illness, small blood vessel disease, and malnutrition increase vulnerability to pressure injuries. Additional external factors, such as excess moisture and tissue exposure to urine or feces, can increase risk.</p> <p>Procedure: 1. Each resident, upon admission, readmission, and/or discharge to/from the facility, will have head-to-toe skin evaluation completed by a licensed nurse. The nurse will document the findings in the EMR (Electronic Medical Record).</p> <p>2. The licensed nurse will complete a weekly skin observation and sign the Body Check form for each week on bath day. 3. Direct care givers for the resident will observe daily for any skin changes and report their findings to the Licensed Nurse. 4. When evaluating the resident's skin, note the condition, if the skin is intact, color, and temperature, and any abnormal findings such as .red areas .blisters .pressure wounds, etc. 5. Risk factor examples that increase a resident's susceptibility to develop or not to heal pressure injuries include, but are not limited to: *Impaired/decreased mobility and decreased functional ability .</p> <p>*Drugs such as steroids that may affect wound healing .</p> <p>*Resident refusal of some aspects of care and treatment.</p> <p>*Exposure of skin to urinary or fecal incontinence</p> <p>*Undernutrition, malnutrition, and hydration deficits .</p> <p>7. It is the responsibility of the Interdisciplinary Care Plan team to review each risk factor and potential cause(s) individually to: a. Identify those that increase the potential for the resident to develop pressure injuries. b. Decide whether and to what extent the factor(s) can be modified, reduced, stabilized, removed, etc. Policy Explanation and Compliance Guidelines:</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>.2. The facility shall establish and utilize a systemic approach for pressure injury prevention and management, including prompt assessment and treatment; intervening to stabilize, reduce or remove underlying risk factors; monitoring the impact of the interventions; and modifying the interventions as appropriate.3. Assessment of Pressure Injury Risk: .c. Licensed nurses will conduct a whole-body skin assessment on all residents .after any newly identified pressure injury. Findings will be documented in the medical record .4. Interventions for Prevention and to Promote Healing: .c. Evidenced-based interventions for prevention will be implemented for all residents who are assessed at risk or who have a pressure injury present. Basic or routine care interventions could include but are not limited to: i. Redistribute pressure (such as repositioning, protecting and/or offloading heels, etc.); ii. Minimize exposure to moisture and keep skin clean, especially of fecal contamination. iii. Provide appropriate, pressure-redistributing support surfaces. iv. Provide non-irritating surfaces. v. Maintain or improve nutrition and hydration status, where feasible .e. The goals and preferences of the resident and/or authorized representative will be included in the plan of care .ii. Compliance with interventions will be documented in the weekly summary charting. 5. Monitoring: a. Weekly, a RN (Registered Nurse) will review all relevant documentation regarding skin assessments, pressure injury risks, progression toward healing, and compliance at least weekly, and document a summary of findings in the medical record. b. The attending physician will be notified of i. The presence of a new pressure injury upon identification. ii. Any complications (such as infection, sinus tract development, etc.) as needed .6. Modifications of Interventions: .b. Interventions on a resident's plan of care will be modified as needed. Considerations for needed modifications include i. Changes in resident's degree of risk for developing a pressure injury .iii. Lack of progression towards healing. iv. Resident's non-compliance .</p> <p>Example 1</p> <p>R1 was admitted to the facility on [DATE] with diagnoses that include, in part: age-related osteoporosis with current pathological fracture of left femur (long bone in the thigh) and superior/inferior pubic rami (two branches of the pubic bone that make up the front of the pelvis); chronic congestive heart failure (a long-term condition where the heart can't pump blood as well as it should); rheumatoid arthritis (a chronic autoimmune disease that primarily affects the joints and causes inflammation, pain, stiffness, and damage to the joints, leading to loss of function and disability); difficulty in walking; and need for assistance with personal cares.</p> <p>R1's admission Minimum Data Set (MDS) dated [DATE] indicates a Brief Interview of Mental Status (BIMS) of 15, indicating R1 is cognitively intact. Section GG Functional Abilities and Goals, indicates, in part: Functional limitation: lower extremity one side. Roll Left to Right: dependent (Helper does all of the effort. Resident does none of the effort to complete the activity). Lying to Sitting: dependent</p> <p>R1's Care Plan includes, in part: 9/18/24: ADL's (Activities of Daily Living) Potential for Alteration in ADL's Related to: Left Femur IMN (Intramedullary nailing (IMN) is a surgical procedure used to treat fractures of the femur, the long bone in the thigh).</p> <p>Approach: Transfers: 2 assist; Mobility: 2 assist; Toileting: 2 assist; Bilateral Assist handles to assist with bed mobility. Urinary .Foley catheter (removed 10/8/24 - need for assistance with toileting) 11/13/24 - Foley placed for wound healing. Enhanced barrier precautions skin.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>(Date is incomplete at top of this portion of the care plan) Nutrition Potential for Alteration in Nutrition related to: Increased needs for healing. Additional Information: .Juven TID (Three Times a Day) (a nutritional supplement), Boost BID (Twice a Day) (nutritional supplement), Thrive Ice Cream PRN (as needed) (nutritional supplement), Gelatine pro Jello BID (High Protein Gelatin). There is a hand written date of 11/13/24.</p> <p>9/18/24: Skin Potential for Alteration in Skin Integrity related to Left hip incision, Left hip hematoma. Approach, in part: Complete skin assessments. Provide treatment as ordered (see TAR (Treatment Administration Record). Reposition per turn schedule: encourage every 2 hours and PRN (Of note, this item is crossed off and discontinued 11/15/24 with initials is written in). Refer to Dietician/designee .Barrier cream with cares .Mattress: air (Of note, this item is crossed off and discontinue 11/15/24 is written in). chair cushion: wc (wheelchair) (does not indicate what type of cushion). Educate on causes of skin breakdown. Confer with wound care specialist PRN (as needed). Measure wound(s) weekly.</p> <p>Additional information and/or updated (date): 10/17/24 use wedges for repositioning (discontinued 11/15/24) 10/16/24 I have a DTI (deep tissue injury) to my R (right) & L (left) buttock, stage 3 to my L buttock. 11/13/24: wound vac (a negative pressure device that helps to heal a PI (pressure injury) placed - L buttock PI.</p> <p>11/14/24 air mattress (standard) changed to United Mattress (combination of memory foam and air cells allow for patients eight to be equally distributed. No electricity or electric pump needed.)</p> <p>11/21/24: heel boots on at HS (bedtime) float heels in bed during day when in bed .</p> <p>On 9/18/24, R1's Braden scale for predicting pressure sore risk, indicates a score of 15, which indicates R1 is at risk.</p> <p>On 9/18/24, R1's Certified Nursing Assistant (CNA) Kardex report indicates the following: Toileting use 2A (two staff to assist) foley/incontinent of bowel offer to toilet Q 3 (every 3) hours and PRN (as needed). Foley cares Q shift. Monitors - monitor alert & oriented times 4, w/c cushion, enhanced barrier precautions r/t (related to) foley catheter. Mobility - transferring 2A Hoyer (full body lift). Bed mobility 2A encourage/assist to reposition Q 2 hours and PRN.</p> <p>On 9/18/24, R1's Skin monitoring CNA/Nurse shower review form indicates R1 does not have any skin impairment to her buttocks.</p> <p>On 9/20/24, R1's CNA Kardex report indicates R1 transferring 2A (two assist) Hoyer WBAT (weight barring as tolerated) to LLE (left lower extremity) and bed mobility L (left) assist rails for bed mobility.</p> <p>On 9/21/24, R1's Braden scale indicates a score of 17, indicating R1 is at risk.</p> <p>On 9/21/24, R1's Skin monitoring CNA/Nurse Shower review form indicates R1 does not have any skin impairment to her bottom/buttocks.</p> <p>On 9/25/24, R1's CNA Kardex report indicates R1 transferring/toileting with EZ stand lift and assist of 2 and Bathing to use EZ stand for transfers with assist of 2. Bed mobility remains 2 A (assist)</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 9/27/24 at 2:45 PM, R1's Nurses note states in part: sheared areas on buttocks with discoloration [sic] surrounding, informed NP (nurse practitioner). Orders to be sent, staff will continue to monitor.</p> <p>On 2/5/25 at 9:40 AM, Surveyor spoke with RN J (Registered Nurse). Surveyor asked RN J what the process is when you find an open area on a resident's skin. RN J stated, she would notify the NP (Nurse Practitioner) and obtain orders. RN J stated, she's not sure if she notified RN D (Registered Nurse), who is the Wound Care Nurse, or if she needs to notify RN D. RN J stated, I'm honestly not sure. Surveyor asked RN J, how does RN D find out there's an open area. RN J stated, they (management) read our documentation every day. RN J stated, all Progress Notes are read by management. Surveyor asked RN J, when you observed and documented a PI to R1's buttock, which buttock was it. RN J stated, she does not recall which buttock, however, she stated it was an upper buttock. RN J added, it was higher on the hip versus a true gluteal (buttock). Surveyor asked RN J, did you document anywhere else. RN J stated, no. Surveyor asked RN J, did you measure and describe the wound. RN J stated, no. Surveyor asked RN J, when you discover a PI, should you measure, assess and document a description of the PI. RN J stated, yes. RN J stated, she verbally reported it to the NP (Nurse Practitioner) face to face when she was in the facility. Surveyor asked RN J, did you get an order. RN J stated, she noted that she reported it to the NP but does not recall getting an order. RN J stated, It would have been documented had I gotten the order. RN J stated the interim treatment was barrier cream (already using prior to development). Surveyor asked RN J, did you put a dressing on the PI. RN J stated, no, not without an order. Surveyor asked RN J, did the NP look at R1's wound. RN J stated, I can't say. Surveyor asked RN J, how often are residents turned and repositioned. RN J stated, it depends on the care plan and if there are any wounds present. RN J stated it's individualized for each resident. Surveyor asked RN J, how often was R1 turned and repositioned. RN J stated she is unsure. Surveyor asked RN J, do staff document turning and repositioning. RN J stated, yes, the nurses (Registered Nurses and Licensed Practical Nurses) document in the TAR (Treatment Administration Record). Surveyor asked RN J, do staff document refusals. RN J stated yes, nurses enter a note to document the refusal. Surveyor asked RN J, what stage is R1's PI. RN J stated, it's a shearing, her skin was sheared off. Surveyor asked RN J, was R1's wound open. RN J stated, yes. Note, there was no documentation of a measurement, stage or description of the PI when it was first discovered.</p> <p>On 9/28/24, R1's Braden scale indicates a score of 17, indicating R1 is at risk.</p> <p>On 9/28/24 R1's Skin monitoring CNA/Nurse Shower review form indicates R1 does not have any skin impairment to her bottom/buttocks.</p> <p>On 9/29/24, the facility's 24-hour board indicates for R1, 9/28/24 monitor open areas to buttocks.</p> <p>On 10/2/24, R1's Telephone order indicates, buttock treatment: cleanse area with soap and water, pat dry, apply foam dressing to affected areas. Change every three days or PRN. May d/c when healed. Foley removal discontinue foley on 10/8/24 at 0600 (6:00 AM).</p> <p>On 10/3/24, R1's CNA Kardex report indicates R1 is dependent of assist of two for lower body with use of [NAME] steady (mechanical stand lift device to assist with standing) for standing. Mobility: [NAME] steady transfers with moderate assist of 2, WBAT to LLE.</p> <p>On 10/5/24, R1's Braden scale indicates a score of 16, indicating R1 is at risk.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 10/6/24, R1's Skin monitoring CNA/Nurse Shower review form indicates R1 has three areas to her left buttock, two areas indicated as scabbed, and one area indicated as open.</p> <p>On 10/7/24, R1's NP Nursing Facility acute visit note, states in part: .seen today for chief complaint of new skin concerns as reported by patient and staff. chief complaint: I have new sores.new skin concern under bilateral breasts .exam: Back: tenderness noted, limited range of motion due to stiffness and pain .skin: abrasions under bilateral breasts.</p> <p>Of note: There is no mention of R1 having open areas to her left and right buttock.</p> <p>On 10/12/24, R1's Braden scale indicates a score of 17, indicating R1 is at risk.</p> <p>On 10/12/24, R1's Skin monitoring CNA/Nurse Shower review form indicates R1 does not have any skin impairment to her bottom/buttocks. Had shower with therapy refused today.</p> <p>On 10/15/24 at 9:51 AM, R1's Nursing Advance Skilled evaluation note, states in part: .Skin: skin warm & dry, skin color WNL (within normal limits) and turgor normal.Skin note: .buttocks with superficial open areas MASD (Moisture associated skin damage), treatment applied as ordered .</p> <p>Of note, there is no description of what the skin tissue looks like or how big the MASD area is.</p> <p>On 10/16/24, R1 has no documentation of her skin for this day.</p> <p>On 10/17/24, R1's CNA Kardex report indicates R1's mobility is maximum assist of 1 for sit to stand transfers with 2ww (two wheeled walker). Bed mobility is 1 assist to reposition Q 2 hours and PRN with wedges, air mattress, Right and left assist rails for bed mobility.</p> <p>On 10/17/24, R1's Telephone order indicates Left buttock cleanse area with soap and water, pat dry, apply Santyl to slough bed, cover with foam dressing, perform daily or PRN. Right buttock cleanse area with soap and water, pat dry, cover wound with vitamin AD, cover with foam dressing, change daily or PRN.</p> <p>On 10/17/24 at 9:51 AM, R1's Nursing Advance Skilled evaluation note, states in part: Skin: .Skin note: . bilateral buttocks with wounds treatment applied.</p> <p>On 10/17/24 at 12:02 PM, R1's Skin/wound note, states in part: Writer assessed area to R buttock at request of floor RN. Upon assessment, dark purple wound, indicative of a DTI, present to superior portion of R buttock. Discolored area measures 1.5cmx1.5cm with irregular edges. Appears to be open in center of wound, with small amount of scattered yellow slough present. Sanguineous drainage noted on dressing. Periwound pink, but blanchable. No odor. Resident did state area is tender. NP updated with assessment and recommendations .</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 10/17/24 at 12:04 PM, R1's Skin/wound note, states in part: Writer assessed area to L buttock at request of floor RN. Upon assessment open area present to superior portion of L buttock, with linear DTI (deep tissue injury) just inferior to it. Open area measures 1cm x 0.7cm and is 100% slough. Based on presence of slough, wound would be classified as unstageable PI. Not currently draining. DTI just inferior to open area, appearing dark purple and measuring 0.5cm x 4cm. periwound of both areas pink, but blanchable. No odor. Resident did state area is tender. NP updated with assessment and recommendation [sic] for the following treatment to be done daily and PRN .Other interventions: offer repositioning Q 2 hrs. and PRN with foam wedges, air mattress, Roho cushion. Will monitor during weekly wound rounds to ensure proper healing.</p> <p>On 2/5/25 at 11:45 AM, Surveyor spoke with RN M (Registered Nurse) and asked what the process is when you find an open area on a resident's skin. RN M stated, staff measure and assess the wound (e.g. granulation, slough, describe the wound), identify risk factors, update MD/NP (Medical Doctor/Nurse Practitioner) to request orders, alert Nurse Manager and Wound Care nurse for follow up. Document all of this in a Progress Note. RN M stated, when she receives the order, she implements the order. Surveyor asked RN M, if unable to obtain the order on the first attempt how soon do you try again. RN M stated, if it's in the morning she would call back after lunch. RN M stated, if it's near the end of her shift she will report it to the next shift and let the Nurse Manager know so they can coordinate. Surveyor asked RN M, how often are residents repositioned. RN M stated, every 1 1/2 to 2 hours or follow care plan if there are specific instructions for a resident. Surveyor asked RN M, how often was R1 repositioned. RN M stated, she believes it was every 2 hours. RN M stated, for CNAs (Certified Nursing Assistants) she believes it was a documented in POC (point of care) charting and in the TAR (Treatment Administration Record) for nurses. Surveyor asked RN M, what do you do if a resident refuses repositioning. RN M stated, she expects CNAs to report to the nurse. The nurse will approach the resident to ask why they are refusing, provide education, document and if still declining, provide education regarding risks and benefits of not having repositioning done. Surveyor asked RN M, if she is familiar with the United Mattress. RN M stated, yes. RN M stated, R1 was the first resident to have the United Mattress in the facility. RN M stated, the vendor provided an in-service regarding the United Mattress to the facility. RN M stated, the in-service topics included the following: Hand pump like a Roho cushion; a Chux can be used with this mattress; May not be necessary to elevate heels or use heel boots; Set-up. RN M stated, she saw R1's wounds on occasion but not consistently. RN M added, R1 had a wound to her right buttock. Surveyor asked RN M, what caused R1's PI's. RN M stated, a poor appetite her nutrition was not well, limited mobility issues, slept a lot, not a lot of motivation, sat in wheelchair for long periods of time with a regular cushion before the Roho cushion was put in place. RN M added, R1 slept a lot, was fatigued and took lots of encouragement to eat. Surveyor asked RN M, how often PI's should be assessed and measured. RN M stated, weekly or if there's a change and it's worsening. Surveyor asked RN M, if you note that a resident's PI is worsening, what should you do. RN M stated, she would measure and assess the PI noting a description, let MD/NP/resident know that it's worsening and may need a different treatment, update Nurse Manager and Wound Care Nurse, document in Progress Notes.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 10/17/24, R1's NP nursing facility acute visit note, states in part: .seen today for follow up for worsening buttock wounds as reported by patient and staff. Chief complaint: I hear they are getting worse.staff and patient are reporting they are getting worse. I had assisted (R1) to the restroom to take a peek. See photos and descriptions below.Skin: left buttock with area of slough, sero-sanguinous [sic] drainage noted, no odor with deep tissue injury below. Right buttock with open area with surrounding erythema, no drainage, tender to touch.A. 1. Unstageable pressure ulcer of left buttock .cleanse with soap and water, pat dry apply Santyl to slough bed. Cover with foam dressing. offer repositioning q 2 hrs. and PRN with foam wedges, air mattress, Roho cushion. 2.pressure ulcer of right buttock, stage 2 .cleanse with soap and water, pat dry, cover wound with vitamin AD cover with foam dressing .</p> <p>Of note, the NP stages this PI as a stage 2 however, mentions the PI has slough; this would make the PI at least a stage 3.</p> <p>On 10/17/24, Maintenance work log indicates, air mattress needed. Air mattress to bed, for skin concerns/wounds present. Assigned on [DATE]. [DATE] at 1:05 PM Standard mattress has been removed in the [sic] primer has been put on.</p> <p>Of note: The facility's standard mattress is a Geo-mattress ultra max. The manufacturer guidelines indication for use states in part: prevention of stage 1-4 pressure injuries .early intervention for multiple stage 1-2 and treatment of single stage 3 pressure injuries .reposition frequently by self or caregiver . The Air mattress that was placed on R1's bed is indicated as a Panacea Air advance mattress. The manufacturer information indication for use, states in part: .provides pressure management to assist in the prevention and treatment of up to Stage IV pressure ulcers. The alternating pressure and low air loss mode provided with the panacea air advance mattress is indicated for use as a preventative tool against further complications associated with critically ill residents or immobility.</p> <p>On 10/19/24, R1's Skin monitoring CNA/Nurse Shower review form indicates R1 does not have any skin impairment to her bottom/buttocks.</p> <p>On 10/23/24, R1's NP Nursing Facility acute visit note, states in part: .seen today for follow up for wounds as reported by patient. Chief complaint: my back hurts.follow up on her buttock wounds. Unfortunately, on appearance they are worsening .both wounds are drainage [sic]. Wound RN (RN D's name) also assessed with me today .A: 1. Unstageable pressure ulcer of left buttock (HCC) comments: .unfortunately worsening. Worry this wound may progress due to underlying hardness felt. Plan: wound care left buttock: cleanse area with soap and water, pat dry apply Santyl to slough bed. Cover with foam dressing. Change daily and PRN. Cushion in wheelchair, air mattress, reposition every 2 hours. Educated staff to provide Roho cushion to recliner. start ProStat (high protein drink to help with wound healing) 30ml daily. 2.Pressure injury of right buttock, unstageable. Comment: .unfortunately worsening. Worry this would [sic] may also progress due to underlying hardness felt. Plan: wound care: Right buttock cleanse with soap and water, pat dry cover apply Santyl to eschar/slough cover with foam dressing. Change daily and PRN.</p> <p>Of note: NP provided education to staff to provide a Roho cushion in her recliner.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525375	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/18/2025
NAME OF PROVIDER OR SUPPLIER Hebron Oaks		STREET ADDRESS, CITY, STATE, ZIP CODE 510 Genomic Drive Madison, WI 53719	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 10/23/24 at 2:34 PM, R1's skin/wound note, states in part: weekly assessment of DTI to R buttock, first noted on 10/16/2024, with assessment completed on 10/23/2024 in presence of NP. DTI is now open, presenting as an unstageable PI. Open area measures 1.8cm x 1.4cm with undeterminable depth due to 100% black eschar within wound bed. Moderate serosanguineous drainage noted on previous dressing . periwound pink blanchable. Hard area noted inferior to open area upon palpation. No odor. Resident did state area is tender . treatment order changed .other interventions: offer repositioning Q2 hrs. and PRN with foam wedges, air mattress, Roho cushion .</p> <p>On 10/23/24 at 2:34 PM, R1's Skin/wound note, states in part: weekly assessment of PI and DTI to L buttock, first noted on 10/16/2024, with assessment completed on 10/23/2024 in presence of NP. Two open areas present on L buttock. Superior open area measures 0.7cm x 0.8cm x <0.1cm. DTI just inferior to open area is now open with a linear scab to the right, presenting of stage 2 PI. Area measures 0.6cm x 1.1cm x <0.1cm. Wound beds of both ~ 80% (approximately 80 percent) yellow slough. Scant light-yellow drainage noted upon cleansing .hard area noted [sic] inferior to open areas upon palpation. No odor. Resident did state area is tender . inferior unstageable PI has improved. Presenting as a healing unstageable PI based on smaller measurements. DTI has deteriorated as it is now open. Will continue to monitor during weekly wound rounds to ensure proper healing.</p> <p>Of note: R1's wounds are indicated as being noted on 10/16/24, but there are no notes in R1's record related to skin on 10/16/24. R1 was noted to have MASD on 10/15/24 - no further assessment was charted on 10/15 or 10/16 of R1's skin.</p> <p>On 10/23/24, R1's Telephone order indicates: Discontinue current right buttock treatment order. Right buttock treatment order cleanse area daily with wound cleanser, pat dry, apply Santyl to eschar/slough wound, cover with foam dressing. Change daily or PRN.</p> <p>On 10/26/24, R1's Skin monitoring CNA/Nurse Shower review form indicates R1 has an open area to her left and right buttock.</p> <p>On 10/28/24, R1's NP Nursing facility acute visit note, states in part: .nurse also tells me patient with scab to buttock, nicker [sic] size, that is starting to pull away from skin. Nurse notes what appears to be some tunneling under the scab. NP noted wounds at appointment on 10/17/24. She reports some discomfort with the wounds. She is concerned they are getting worse also patient tells me she sits I [sic] wheelchair most of the time. She does have a cushion in her chair. She is a 1 assist for transfers . Right buttock wound: there is about 3-4cm of undermining/tunneling of this wound. There is moist slough noted in wound bed. There is some odor. There is no erythema or warmth. (of note, left buttock wound was noted, but no description with photo given) .A right buttock, stage 3 .some undermining noted .pressure injury of left buttock, stage2 . seems stable from previous photo .encourage lying in bed with side-side positioning to encourage pressure relief .</p> <p>On 10/28/24 at 12:49 PM, R1's Health status note, states in part: .NP and writer assessed resident wound to right buttock at approximately 1130 today. Wound measures 2cm x1cm with a black scab partially intact held by slough tissue. Black scab has separated from skin partially and wound has a depth of 4.5cm at 6 o'clock and 4.5cm at 10 o'clock. Moderate amount of light red serious drainage noted. New orders received for new dressing change to be completed this evening.</p> <p>On 10/28/24 at 12:54 PM, R1's health status note, states in part: Correction: wound depth at 10 o'clock is 3cm.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 10/28/24, R1's Telephone order indicates cleanse/flush right buttock wound with wound cleanser, pat dry, pack with iodoforn, cover with gauze, then Mepilex daily and PRN.</p> <p>On 10/30/24, R1's CNA Kardex report indicates R1 has a wheel chair Roho cushion to seat and Roho to w/c back.</p> <p>On 10/30/24 at 10:04 AM, R1's Skin/wound note, states in part: . weekly assessment of DTI to right buttock, first noted on 10/16/24. Open area measures 2.3 cm x 1.4 cm, with a depth of 4 cm. no eschar noted . resident states that pain of wound is 9/10.(R1) answers that she has had boils on her bottom previously, but it has been many years.</p> <p>Of note: there is no facility measurement or assessment for the L buttock wound.</p> <p>On 10/30/24 at 1:32 PM, R1's Skin/wound note, states in part: .met with resident and daughter to discuss wound status and current interventions Resident shared personal goal of more independent repositioning and offloading more frequently. Care plan clarification requested by resident to utilize lift sheet as primary tool to assist with repositioning in bed Daughter shared she had been providing a firm lumbar support device in resident's w/c and that after evaluating, she will be taking this device home as it rubs to the wounded area. Request for Roho style cushion to be provided for w/c back support surface .</p> <p>On 2/5/25 at 8:35 AM, Surveyor spoke with FM I (Family Member). Surveyor asked FM I, when did R1 start using a lumbar support. FM I stated, R1 had the lumbar support before R1 fell and fractured prior to admission. FM I stated, the lumbar support was used for musculoskeletal back pain. FM I stated, the lumbar support was used intermittently not all the time. FM I added, it was not particularly helpful for R1. FM I stated, R1 used the lumbar support at the facility when she was still having pain from pelvic fractures when sitting in her wheelchair. FM I stated, R1 did not tolerate time in the wheelchair for the first 2-3 weeks. FM I added, R1 spent a lot of time in bed flat on her back. Surveyor asked FM I, did you speak with anybody at the facility regarding the lumbar support. FM I stated, she spoke with PTA K (Physical Therapy Assistant). FM I stated, when she visited R1, she observed staff, Dragging her bare hind end (while assisting her in bed). FM I stated, due to shear forces this put R1 at risk for injury. FM I further stated, when staff would reposition R1 they would do so without a draw sheet. FM I added, she also observed R1 sitting on a Hoyer sling while up in her wheelchair or recliner. FM I stated, she doubts staff was repositioning R1 every 2 hours at night. FM I stated, Staff didn't offload (pressure) like they needed to. FM I added, a nurse (name unknown) told her we don't know what we are doing with the wound vac. FM I stated, the facility lacks general oversight and training of staff. A supervisor told staff, here's a video to watch (related to wound vacs).</p> <p>On 2/5/25 at 9:30 AM, Surveyor spoke with PTA K (Physical Therapy Assistant). Surveyor asked PTA K, when R1 was admitted to the facility was she able to turn and r [TRUNCATED]</p>		

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<p>F 0730</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Observe each nurse aide's job performance and give regular training.</p> <p>30992</p> <p>Based on record review and staff interviews, the facility did not complete a performance review of every nurse aide at least every 12 months for 5 of 5 Certified Nursing Assistants (CNAs) reviewed for in-service training.</p> <p>The survey team randomly selected five (5) facility CNAs who have been employed at the facility for longer than one (1) year. CNA/MT O (Certified Nursing Assistant/Medication Technician), CNA/MT P (Certified Nursing Assistant/Medication Technician), CNA Q (Certified Nursing Assistant), CNA R (Certified Nursing Assistant), and CNA S (Certified Nursing Assistant) did not have a performance review at least every 12 months.</p> <p>Findings include:</p> <p>Surveyor provided NHA A (Nursing Home Administrator) with a list of five CNA names the Surveyor had randomly selected and requested their performance review for the past 12 months.</p> <p>Surveyor reviewed performance review records and noted the following:</p> <p>Surveyor reviewed performance reviews from 2/18/24 -2/18/25. During this time, CNA/MT O, CNA/MT P, CNA Q, CNA R, and CNA S had no performance reviews completed.</p> <p>On 2/18/25 at 2:40 PM, Surveyor spoke with NHA A (Nursing Home Administrator). Surveyor asked NHA A, do you expect CNAs to have a performance review at least every 12 months. NHA A stated, yes. NHA A stated, RN's (Registered Nurses) and LPN's (Licensed Practical Nurses) had a performance evaluation completed. NHA A stated, the facility was confused with what to do with their CNAs that are in a union and have not been completing performance reviews for any CNAs. NHA A stated, moving forward, yes, there will be a performance review of CNA at least every 12 months.</p>