STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525402	A. Building B. Wing	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willow Ridge Healthcare	400 Deronda St Amery, WI 54001

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review, the facility did not ensure food was stored and prepared in a sanitary manner. This practice had the potential to affect all 26 residents residing in the facility.Surveyor observed a scoop left in the flour storage bin.Missed opportunities for litmus testing of sanitation solution (red bucket) in cook's area. Logs for sanitizer bucket Parts Per Million (PPM) and sanitization levels were not completed.Findings include:Example 1The facility policy, title Food Storage Standards, states:3. Criteria for Dry Food Storage.f. Working containers holding dry food or ingredients that are removed from their original packages are identified with the common name of the food, unless the food is easily recognizable such as pasta.g. Staff receives training on the proper dry food storage.4. Quality Assurance:d. Training records are evaluated to make sure all dietary employees have received training in the proper storage of foods; training records are maintained. On 7/29/25 at 11:32 AM, Surveyor observed the kitchen and meal service. [NAME] O showed Surveyor where the flour and sugar were kept. [NAME] O opened both bins for Surveyor to observe, as scoop was in the sugar. [NAME] O did not remove it. Surveyor interviewed [NAME] O. [NAME] O stated that training is completed on the CE Solutions, it includes food safety and handling. On 7/29/2 at 11:32 AM, Surveyor interviewed [NAME] K who stated that scoops and items are not left to be used later. The 3-compartment sink is used to clean large pots, and smaller items are sent back to the dishwasher.On 7/30/25 at 8:34 AM, Surveyor interviewed Dietary Manager (DM) N who stated flour and sugar are kept in large bins right by mixer. DM N stated that she does the refilling of bins. DM N lets them get almost empty, dumps out and washes out the bin, lets dry completely, refills, and labels what it is and date with masking tape. DM N stated that scoops are always cleaned and kept right by the bins. Use it and put the scoop in back to go through a dishwasher. Surveyor asked DM N to observe the bins with Surveyor. DM N opened the sugar and looked at Surveyor, They left a scoop, that should not be in there. I can't believe they did that. Surveyor and DM N discussed training logs and expectations. CE Solutions is used for training and where logs are kept.Example 2 Sanitizing SolutionNo facility policy for review.FDA Food Code, 2022 at 4-501.114 Manual and Mechanical Warewashing Equipment, Chemical Sanitization - Temperature, pH, Concentration, and Hardness indicated: A chemical sanitizer used in a sanitizing solution for a manual or mechanical operation at contact times specified under 4-703.11(C) shall meet the criteria specified under 7-204.11 Sanitizers, Criteria, shall be used in accordance with the EPA-registered label use instructions.FDA Food Code, 2022 at 4-501.116 Warewashing Equipment, Determining Chemical Sanitizer Concentration. Concentration of the sanitizing solution shall be accurately determined by using a test kit or other device.Surveyor reviewed the facility log, titled Litmus Testing- Bucket System (Red Bucket) reviewed. The top of the log has spot for month and year, directions to see Quaternary Test Poster, record results below, Dash specs if not used. The bottom of the log states [NAME] Range PPM: 150 to 400 PPM. If out of range, you must either contact maintenance or the dietary director and documented (date/initial) by temperature that you have done so. The log has columns for the date, time, temp, PPM and staff initials. In April 2025 there were 30 days and 90 opportunities to test PPM, (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	there were 17 opportunities missed: 4/2 PM, 4/6 PM, 4/8 PM, 4/16 AM, Noon and PM, 4/18 PM, 4/19 PM, 4/20 PM, 4/21 Noon and PM, 4/22 PM,4/24 PM, 4/25 Noon and PM, 4/30 Noon and PM. 24 PPM measurements were out of range and unclear if followed up on. There are initials in the same column for dates in range and out of range. In May unclear testing continues; there are no dates where testing PPM was missed but 30 tests were out of range and unclear if followed up on. There are initials in the same column for dates in range and out of range. In June 2025, there were 30 days and 90 opportunities to test PPM or for PPM to be out of range, 2 opportunities were missed: 6/14, 6/26 and 10 PPM testing that are out of range and unclear if followed up on. There are initials in the same column for dates in range and out of range. In July 2025, there have been 28 full days of meals before Surveyor entered the kitchen or 75 opportunities to test PPM: 7/5 AM, 7/7 noon and PM, 7/16 AM, 7/19 AM, 7/28 noon and PMOn 7/29/25 at 10:20 AM, Surveyor interviewed DM N regarding requirements for monitoring sanitizing solution ppm and concentration. DM N stated there is a log and staff do it at every meal. DM N pulled up computer and attempted to find a policy. Policy was not found and one was not brought forward at a later time. On 7/29/25 at 11:32 AM, Surveyor interviewed [NAME] K and [NAME] O. [NAME] K stated the red bucket kept by the 3 compartment sink is the cook's sanitizing solution. Solution is made each meal and as needed. [NAME] O stated it was cook's responsibility to check the PPM level and record it on the log. [NAME] N showed Surveyor where the strips were kept. [NAME] K stated we let DM N know whenever we need something or there is a problem.On 7/30/25 at 10:40 AM, Surveyor interviewed DM N to clarify what it means when spots are scribbled out. DM N stated, I don't know what is going on there. I guess it was a missed test.

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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. Based on interview and record review, the facility did not ensure that 1 of 8 employees were screened for a history of abuse, neglect, exploitation, or misappropriation of resident property to prohibit abuse, neglect, and exploitation of resident property, as state and federal regulations require. -Facility did not screen Registered Nurse (RN) H for an out of state Background Information Disclosure (BID) when hired. Findings include:Surveyor reviewed facility policy titled, Resident Safety Abuse Policy, dated revised on 02/2022, stated in part: .#3. a. Employee Screening:i. All individuals considered for employment shall receive a reference check. All responses shall be documented. The reference sources shall be asked about job performance, skills, habits, and reliability.ii. All employees shall have a criminal background check.1. Initial and any required future background checks will be conducted in accordance with applicable state and federal laws. Checks may include criminal history, state caregiver registry, OIG, and exclusion lists. The type frequency, and timing of checks will be in accordance with applicable state and federal law . Surveyor reviewed background checks. RN H filled out BID on 07/08/24. RN H answered question #4 that RN H lived in Minnesota in the last 3 years. Facility did not run a background for Minnesota. The BID was run for RN H on 08/27/24 through Wisconsin database but not Minnesota. On 07/29/25 at 10:01 AM, Surveyor interviewed Business Office Manager (BOM) E and asked about the missing Minnesota background check for RN H. BOM E reported to Surveyor that BOM E is unsure how that got missed. Usually, corporate will let BOM E know when to run an out of state background check. BOM E reported the facility will start running it now. BOM E reported to Surveyor that RN H does not have the background complete, and it was not completed prior to Surveyors' arrival to facility for this survey.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not develop and implement a comprehensive care plan for each resident (R) to meet medical, nursing, and psychosocial needs identified for 2 of 12 sampled residents (R0 (R3 and R8).R3 and R8 did not have a sleep hygiene care plan developed when prescribed medication to promote sleep.This is evidenced by:Example 1R3 was admitted to the facility on [DATE]. R3's current diagnoses include in part, cerebral infarction, type 2 diabetes mellitus, anxiety, aphasia, hemiplegia right dominant side, narcolepsy, and atrial fibrillation.R3's physician orders documented an order on 03/01/25 to give melatonin 5 mg by mouth daily HS (bedtime) for insomnia.On 06/26/25, a sleep assessment was completed documenting R3 on average sleeps 7-8 hours with a goal of 8 hours and try to avoid excess fluid intake. Review of R3's care plans did not document a sleep hygiene care plan was developed with non-pharmacological interventions to promote sleep. Example 2R8 was admitted to the facility on [DATE]. R8's current diagnoses include in part, encephalopathy, weakness, Alzheimer's disease with late onset, depression, anxiety disorder, and chronic kidney disease stage 3b. R8's physician orders documented orders on 07/03/23 melatonin 3 mg tablet dose by mouth daily prn insomnia and 09/29/23 melatonin 5 mg tablet dose by mouth daily PM insomnia. On 07/30/25 at 11:23 AM, Surveyor interviewed Quality Consultant Registered Nurse (RN) G about R3 and R8's sleep hygiene care plans for use of melatonin. RN G stated there was not a care plan developed for sleep for R3 and R8, and a care plan is entered now.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure a resident received treatment and care in accordance with professional standards of practice for 1 out of 12 residents (R) reviewed, R14.Facility staff did not follow R14's physician orders for administration of insulin.This is evidenced by: R14 was admitted to the facility on [DATE]. R14's current diagnoses include type 2 diabetes mellitus, vascular dementia, and adult failure to thrive. R14's cognition is moderately impaired and requires staff supervision when eating. Review of R14's physician medication orders documented in part. 03/05/24 Insulin Glargine 22 units daily in AM, FOR: type 2 diabetes mellitus.04/9/24 Insulin Lispro 8 unit twice a day at Breakfast and Midday (Lunch) HOLD if meal intake is less than 25%, FOR type 2 diabetes mellitus.04/9/24 Insulin Lispro 6 units daily at Supper. HOLD if meal intake is less than 25%, FOR: type 2 diabetes mellitus.11/12/24 Blood sugar check: Blood Glucose Checks twice a day pattern: Monday Wednesday Friday Sunday 0800 and 1600. Notify physician if blood sugar < 70 if symptomatic and protocol treatment fails. Notify physician if blood sugar > 400 x 2 or if symptomatic for hyperglycemia/hypoglycemia.11/12/24 Blood sugar check: twice a day Tuesday, Thursday, Saturday 1200 and 2000 (diabetes). Notify physician if blood sugar < 70 if symptomatic and protocol treatment fails. Notify physician if blood sugar > 400 x 2 or if symptomatic for hyperglycemia/hypoglycemia.Review of meal intake charting for 06/12/25 documented R14 refused breakfast. The medication administration record (MAR) documented on 06/12/25 at 9:39 AM Insulin Lispro 8 units was administered to R14.Review of meal intake charting for 07/09/25 documented R14 refused lunch. The MAR documented on 07/09/25 at 1:15 PM Insulin Lispro 8 units was administered to R14.Review of meal intake charting for 07/15/25 documented R14 refused supper. The MAR documented on 07/15/25 at 6:30 PM Insulin Lispro 6 units was administered to R14. On 07/30/25 at 5:46 PM, Surveyor interviewed Quality Consultant Register Nurse (RN) G about the times R14 had no meal intakes and insulin Lispro was given, against the physician orders. RN G stated the physician order was not followed. RN G will clarify the order with the physician.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not ensure that 1 of 3 residents (R) reviewed for pressure injuries (PI) (R4) received care consistent with professional standards of practice to prevent the development of a new pressure injury and did not ensure the plan of care was consistently followed for R4, who is at risk for pressure injuries. R4 was at risk for PI development. R4 had an area of concern on right heel. The facility failed to provide adequate and consistent repositioning to off load R4's heels and buttock. This is evidenced by:Guidelines from the National Pressure Injury Advisory Panel (NPIAP) 2016, Pressure Injury Prevention Points, accessed 31, July 2025, Prevention Points | National Pressure Ulcer Advisory Panel (npiap.com), states in part: Turn and reposition all individuals at risk for pressure injury, turn the individual into a 30-degree side-lying position and use your hand to determine if the sacrum is off the bed, ensure that the heels are free from the bed, use heel offloading devices for high-risk pressure injuries.Surveyor reviewed Manufacturing instructions for NyOrtho Zero-G Boot, dated 2023, which stated in part, .How to measure NyOrtho Zero-G boot.-To choose the correct size measure the circumference of the lower part of the calf muscle.Model:-9518-S Small 5-10inches Petite-9518-M Medium 11-20inches Adult-9518-L Large 21-25inches Bariatric.Surveyor reviewed facility protocol titled, Skin Treatment Management and Guidelines dated last revised on 06/2023, which stated in part, .Deep Tissue Pressure Injury: Intact or no intact skin with localized area of non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing dark wound bed or blood-filled blister. Pain and temperature change precede skin color changes. This injury results from intense and/or prolonged pressure and shear forces at the bone muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury or may resolve without tissue loss. Support interventions for DTPIs:-Support surface/seating system-Turning and repositioning-Heel off-loading-Nutritional Support-Pain management.R4 was admitted to the facility on [DATE] with diagnoses including, in part, unspecified dementia, anemia, hypertension, benign prostatic hyperplasia, Diabetic Mellitus, hyponatremia, hyperlipidemia, depression, and glaucoma.R4's Minimum Data Set (MDS) assessment, dated 07/02/25, identified R4 required total dependent assistance of two people for bed mobility, taking on and off footwear, rolling left to right, sit to lying, chair to bed, toileting, and for transfers. MDS also indicated that R4 was determined to be at risk for PIs and previous MDS dated [DATE] indicated R4 had multiple stage 2 PIs and 2 unstageable PIs that are now healed.Surveyor reviewed R4's Pressure Injury Care Plan dated 07/28/25:- On 07/08/25 skin care: Lotion with cares, barrier cream with all peri care/incontinence cares, be sure blankets are over bed cradle to protect toes. Resident has area of concern on right heel. Position and float right heel on pillows off bed surface. Padding to be placed on the end of resident bed for extra cushion.-On 07/28/25, Nurses to assess skin status, keep provider informed, administer analgesics as ordered, and follow medical plan for treatment.- On 07/28/25, Nurse aide to keep skin clean and dry, encourage and assist to reposition. Inspect skin every shift and report changes. - On 07/28/25, Turning/repositioning assist of 2. R4 will need to be laid down following breakfast and lunch. Use slip sheet for repositioning, reposition every 1 hour and as needed to relieve pain while in bed or in wheelchair, be sure to position pillows on alternating sides for pressure relief on buttock. Ensure proper placement of feet in bed, drape a blanket over footboard for additional padding. Surveyor reviewed physician orders which include:.-On 09/20/23-Cradle on resident bed, resident to wear blue boots while in bed and foam heel protector on right foot at all times when up.-On 09/20/23-Resident to lay down following breakfast and lunch to off load.-06/25/25-Cleanse 3rd toe with wound cleanser, paint iodine and cover with band aide daily.-On 07/09/25-Monitor for skin integrity changed of feet and foam boots, Prevalon always boots both foot/feet daily.-On 07/17/25- Apply Meplix bordered foam or equal to right buttock. Do not use cornstarch.-On 07/22/25- Reposition every hour.Surveyor reviewed R4's progress notesOn 07/28/25 (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at 1:45 PM, Surveyor observed nursing students transfer R4 to bed. Surveyor observed nursing students exit room. Surveyor looked in R4's room and observed R4 lying on left side in bed. Surveyor observed R4's heels have Nyortho Zero-G boots on, blanket was lying on top of R4's toes and R4's heels were touching flat on bed. Surveyor did not observe R4's heels floated to decrease pressure and off load R4's heels while lying in bed. Surveyor did not observe R4's blanket draped over foot guard to protect R4's toes from pressure.On 07/29/25 at 7:55 AM, Surveyor observed nursing student getting R4 up for breakfast. R4s heels have Nyortho Zero-G boots on, blanket was lying on top of R4's toes and R4's heels were touching flat on bed.Surveyor did not observe R4's heels floated to decrease pressure and off load R4's heels while lying in bed. Surveyor did not observe R4's blanket draped over foot guard to protect R4's toes from pressure.On 07/29/25 at 8:05 AM, Surveyor observed nursing student bring R4 down to dining room for breakfast.Continuous observation from 9:01 AM -11:14 AM:On 07/29/25 at 9:01 AM, Surveyor observed R4 lying back in bed after breakfast on back. Surveyor observed R4's heels have Nyortho Zero-G boots on, blanket was lying on top of R4's toes and R4's heels were touching flat on bed. Surveyor did not observe R4's heels floated to decrease pressure and off load R4's heels while lying in bed. Surveyor did not observe R4's blanket draped over foot guard to protect R4's toes from pressure.On 07/29/25 at 10:59 AM, Surveyor observed R4 lying on back in bed. Surveyor observed R4's heels have Nyortho Zero-G boots on, blanket was lying on top of R4's toes and R4's heels were touching flat on bed.On 07/30/2025 at 11:14 AM, Surveyor interviewed Certified Nursing Assistant (CNA) F and asked CNA F if CNA F knows what size R4's Nyortho Zero-G boots are. CNA F reported to Surveyor that CNA F is unsure about the Nyortho Zero-G boot. Surveyor asked CNA F how CNA F knows what size Nyortho Zero-G boot to utilize once Nyortho Zero-G boots are ordered for residents. CNA F reported to Surveyor that CNA F did not know there are different sizes. Surveyor asked CNA F to enter R4's room together to assess R4's Nyortho Zero-G boots and position of R4. CNA F reported to Surveyor that R4's feet should be elevated, and CNA F observed R4's bilateral heels touching flat on bed surface. Surveyor asked CNA F if CNA F could place hand under R4's feet and let Surveyor know if R4's heels are touching bed surface. CNA F reported that R4's bilateral heels were in fact touching the bed surface through the Nyortho Zero-G boots. Surveyor asked CNA F to peek at the size of R4's Nyortho Zero-G boots. CNA F reported to Surveyor that R4's Nyortho Zero-G boots are size large bariatric size on the tag. Surveyor asked CNA F if it is still CNA's duty to check after nursing students to make sure R4 is receiving the correct care for repositioning per R4's care plan. CNA F reported to Surveyor that CNAs should still be following R4's care plan and checking to make sure it is completed but sometimes nursing instructor does not make it easy for regular staff to complete staff's duties if nursing students have certain residents. Surveyor asked CNA F if R4's blanket is supposed to be draped over foot guard to prevent pressure on R4's toes. CNA F reported to Surveyor that R4's blanket should not be lying on top of R4's toes. CNA F repositioned R4 and laid blanket off R4's toes and unto the foot guard. On 07/30/2025 at 11:25 AM, Surveyor interviewed Licensed Practical Nurse (LPN) C and asked RN if R4 is supposed to have a Meplix on R4's right buttock. LPN C reported to Surveyor after looking in R4's physician orders that R4 is to have Meplix on right buttock to protect recent breakdown from discovery on 07/17/25. Surveyor asked LPN C if LPN C placed a Meplix on R4 yesterday 07/29/25 or today on 07/30/25. LPN C reported to Surveyor that LPN C did not place a Meplix on R4 because staff have not reported to LPN C that R4 needs it on R4's buttock. LPN C reported that today was R4's shower day. Surveyor asked LPN C to enter R4's room and observe if Meplix was on R4's right buttock. On 07/30/2025 at 11:33 AM, Surveyor observed LPN C enter R4's room and completed hand hygiene. LPN C then had nursing students roll R4 unto left side, and LPN C noted there was not a Meplix to R4's buttock area on right side. LPN C cleansed area and stated, Right buttocks slightly red in this area, I will place a Meplix. Surveyor observed LPN C place Meplix on R4's right buttock. On 07/30/25 at 12:16 PM, Surveyor interviewed Regional Corporate RN G and asked if RN G, Director of Nursing (DON) B, and Surveyor could go correctly measure R4's boot for proper measurement. RN G reported to Surveyor (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that once R4 is out of dining room for lunch that RN G, DON B, and Surveyor can enter R4's room to measure calf. On 07/30/25 at 1:32 PM, Surveyor asked DON B and RN G to measure mid-calf for correct measurements of Nyortho Zero-G boot utilized to prevent pressure for R4. RN G measured calf and noted it was 12 inches in circumference. DON B and RN G reported to Surveyor that R4 is wearing incorrect boot sizes and needs to be a medium size instead of a large size.On 07/30/25 at 1:35 PM, Surveyor interviewed DON B and asked DON B's expectation for R4's intervention to relieve pressure due to R4's at risk for skin breakdown, past PIs, and current concern for R4's right heel. Surveyor reported to DON B that for the last 3-day observation of R4's repositioning and cares, Surveyor observed R4 not being repositioned every hour as care plans states, and R4's feet were not elevated with blanket over foot guard to prevent further pressure from occurring. DON B reported to Surveyor that expectation would be that staff are still responsible for R4 even if nursing students are providing the care and staff should have made sure that R4's heels and toes are relieved from pressure. Surveyor reported to DON B that R4's boots are incorrect size. Surveyor asked DON B who is responsible for measuring the boots appropriately. DON B stated, I guess that is the wound care nurse's job when ordering boots. Surveyor asked DON B if wound care nurse measured R4's boots. DON B stated, Obviously not because he has the wrong size boots on. Surveyor asked DON B where documentation for R4's right heel and toes assessments were as the notes were not given to Surveyor after requesting. DON B reported to Surveyor that R4 does not have any PI injuries. Surveyor reported to DON B that through documentation Surveyor reviewed it is noted that R4 has had multiple Deep Tissue Injury (DTI) to toes bilaterally and on right heel. DON B reported to Surveyor that R4's DTIs are not pressure related. Surveyor explained to DON B the definition of a DTI. DON B reported to Surveyor that DON B does not acknowledge that a DTI is a pressure injury. Surveyor asked DON B what resources DON B utilizes to define DTI and what guidelines do you follow. DON B reported to Surveyor that DON B utilizes the NPIAP guidelines for wound management along with facility protocol on wound management.On 07/30/25 at 2:21 PM, Surveyor interviewed DON B with RN G and NHA A present in DON B's office. Surveyor asked DON B, since DON B does not acknowledge that a DTI is considered a PI, then what resource does DON B utilize to assess and treat PIs. DON B reported to Surveyor that DON B in the wound care class that DON B took it never discussed a DTI as a PI. DON B reported to Surveyor that DON B utilizes the wound care protocol of the facility. Surveyor requested a copy of the Wound Care protocol. Surveyor asked DON B and RN G if one could follow Surveyor into R4's room to observe R4's position and heels. RN G and NHA A offered to assist Surveyor. On 07/30/25 at 2:25 PM, Surveyor, RN G and NHA A entered R4's room and observed R4 lying on back in bed. Surveyor, RN G and NHA A observed R4's heels have Nyortho Zero-G boots on, blanket was lying on top of R4's toes and R4's heels were touching flat on bed. RN G immediately repositioned R4's feet to float heels by placing pillow under R4. RN G took R4's boots off to examine and assess R4's heels bilaterally. Surveyor observed left heel intact and no concerns. Surveyor and RN G assessed R4's right heel. RN G stated, Still blanchable but I do feel some bogginess, and I see peeling of skin on right heel, could be dry skin but at this point I will document this as a finding of an area of concern.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not ensure the resident's environment remains as free of accident hazards as possible. The facility did not ensure staff followed transfer precautions and supervision when needed to prevent accidents which effected 1 of 4 residents (R2) reviewed for falls. -Certified Nurse Assistant (CNA) D transferred R2 from wheelchair to bed without gait belt in place during transfer process.Findings include:R2 was admitted to the facility on [DATE] with diagnoses including, in part, right above the knee amputation, unspecified dementia, Huntington's disease, chorea, neurocognitive disorder, heart valve replacement, and depression.R2's Minimum Data Set (MDS) assessment, dated 07/17/25, identified R2 required partial to moderate assistance with transferring and R2 has a lower impairment to one side. Surveyor reviewed R2s care plan:-Assist of 2 for transfers with gait belt, not appropriate prosthetic leg. Locomotion in wheelchair.On 07/29/25 at 9:51 AM, Surveyor observed CNA D and CNA F enter R2's room. CNA D applied gloves and began prepping R2's bed to transfer R2 into bed. Surveyor observed CNA D hug R2 and instruct R2 to hug CNA D back. CNA D stood R2 and pivoted R2 on one leg to bed. CNA D sat R2 down on edge of bed. CNA F stood behind R2's wheelchair and stated, Oh she is still on edge of bed, be careful. CNA D quickly boosted R2 back into bed further before letting go of R2. Surveyor did not observe CNA D utilize gait belt during R2's transfer. Surveyor also observed right side of R2's wheelchair was not locked upon the stand pivot transfer. On 07/29/25 at 1:35 PM, Surveyor observed CNA D and CNA F place R2 down in bed. CNA D and CNA F used a stand pivot transfer to place R2 in bed. Surveyor did not observe CNA D and CNA F utilize a gait belt during R2's stand pivot transfer.On 07/29/25 at 1:45 PM, Surveyor interviewed CNA D and asked what CNA D's correct process for transfers with R2 is. CNA D reported to Surveyor that with R2 it is care planned that staff does not use a gait belt during transfers with R2 since R2 is on anticoagulants. Surveyor reviewed care plan and could not find that R2 is not to use a gait belt during R2's transfers. On 07/30/25 at 5:35 PM, Surveyor interviewed Regional Corporate RN G and asked what is R2's care plan for transfers. RN G reported to Surveyor that R2 is assist of 2 with gait belt. Surveyor reported to RN G the observation of CNAs stand pivot transferring R2 to bed from wheelchair. RN G reported that CNAs should have used gait belt and assist of 2 to transfer due to R2 being at risk for falls from R2 flailing around and sometimes hard to transfer.

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Willow Ridge Healthcare	400 Deronda St Amery, WI 54001

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility did not ensure that 1 of 1 resident (R) reviewed received appropriate respiratory care during administration of respiratory treatments (R5). This is evidenced by:The facility procedure Using Small Volume Nebulizers, from book titled Clinical Nursing Skills and Techniques 11th edition, by [NAME] which states: Assessment6. Perform hand hygiene. Assess pulse, respirations, breath sounds, pulse oximetry, and peak flow meter (if ordered) before beginning treatment. Implementation12. Rinse nebulizer cup per agency policy.R5 was admitted to the facility on [DATE] and has diagnoses that include tetralogy of fallot, COPD, acute respiratory failure with hypoxia, macrocephaly, disturbances of salivary secretion, anxiety disorder and persistent mood affective disorder.R5's Minimum Data Set (MDS) assessment, completed on 5/29/25, confirmed R5 has poor hearing and no speech and does not understand and rarely is understood. R5 is unable to make decisions due to her cognitive skills and is dependent for mobility, transfers and all cares.R5's physician orders include Albuterol Sulfate 2.5mg/3ml, Budesonide 0.25mg/2ml suspension inhalation twice a day. Apply vest therapy for 15 minutes during nebulizer treatments BID. (Vest therapy refers to a vest patients wear that applies mild vibration to break up respiratory secretions caught in the lungs.)R5's care plan, dated 6/24/25, states: Monitor breathing, neuro status and vitals, prevent obstruction of air way by elevating head of bed 30 degreesOn 7/28/25 at 4:34 PM, Surveyor observed Nurse Tech (NT) J administer R5's Albuterol nebulizer treatment followed by a Budesonide nebulizer treatment. Respiratory treatments were done at the same time as caring for tube feeding. At beginning of the cares, NT J used clean technique to assemble the nebulizer equipment, placed Albuterol nebulizer solution in cup, attached it to the mask, applied the mask to R5 and started the machine and treatment.At this point the Albuterol nebulizer was completed. NT J set up and started the Bedesonide nebulizer. The vest turned off at 15-minute mark and shortly after the second nebulizer treatment was done. NT J took off nebulizer mask and vest and put aside. NT J stated NT J was behind so NT J will clean this later. NT J stated NT J will rinse it before R5's next nebulizer at 8:30. We clean set ups once a shift. NT J did not assess lung sounds or do an oximetry prior to the updraft between, or after nebulizer treatment. On 07/30/25 at 1:43 PM, Surveyor interviewed Licensed Practical Nurse (LPN) I, who stated that assessment of lung sounds should be done before you start a nebulizer treatment.On 07/30/25 at 1:43 PM, Surveyor interviewed Director of Nursing (DON) B who stated DON B expects lung sounds to be assessed prior to nebulizer treatment. Surveyor asked DON B about cleaning of nebulizer supplies. DON B stated they are cleaned once a shift and at least rinsed in-between uses. On 07/30/25 at 4:09 PM Surveyor followed up with DON B about policies related to lung assessment before nebulizer treatment. DON B stated I don't have one right now, that's standard procedure.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment, to help prevent the development and transmission of communicable diseases and infection. Licensed Practical Nurse (LPN) M observed administering medication for 2 consecutive hours with improper hand hygiene opportunities for 4 of 4 residents observed. (R11, R18, R19, R22).Staff did not wear appropriate PPE for cares with R5 and R1.Staff did not perform hand hygiene when needed during cares for R14.Findings include: Example 1 The facility policy, titled Standard and Transmission-Based Precautions, dated 1/2025, states: 1. Hand Hygiene: a. Hand hygiene refers to hand washing with soap and water OR using alcohol-based hand rubs (gels, foams, rinsed) that do not required access to water. Policy attachment, titled Hand Hygiene: Why, How, & When? states: When? Your 5 Moments for Hand Hygiene 1. Before touching a patient . 2. Before Clean/Aseptic Procedure. d) Before Preparing food, medications. On 7/29/25 at 7:04 AM, Surveyor observed LPN M return to the cart with garbage in her hand when Surveyor was waiting to start observing medication pass. Surveyor observed LPN M throw the garbage in her hand away, lifted the screen and found her next patient on the computer. LPN M opened medication cart, pulled a medication cup and started pulling and preparing medication for R22. No hand hygiene was observed. When LPN M had medication ready, LPN M lowered computer screen, locked cart and took medication to R22 who was sitting on other side of nurse's desk. Medication was administered to R22. LPN M came back to medication cart, threw garbage away, and started to push medication cart towards hallway. No hand hygiene was observed. On 7/29/25 at 7:10 AM, Surveyor observed LPN M prep medication for R19. No hand hygiene before prep and after pushing medication cart down the hall. Medication prepped, taken to administer to R19, administered medication and came back to medication cart. No hand hygiene before entering or leaving R19's room. LPN M did wipe hands with a sanitary towelette when returning to medication cart. Surveyor noticed wipes on cart from the beginning; this was the first time LPN M used them. On 7/29/25 at 7:16 AM, Surveyor observed LPN M prep medication for R18. Medication taken to room for administration. No hand hygiene leaving the cart, going into R18's room or when leaving the room. On 7/29/25 at 8:02 AM, Surveyor observed LPN M prep medications for R11. Still no hand hygiene (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	since beginning of the last medication pass. R11's medications were prepped, taken to R11's room. No hand hygiene before entering R11's room. LPN M gave medications to R11, no hand hygiene, put on gloves, placed eyedrops, with same gloves on and rubbed Lidocaine on R11's neck. LPN M took off gloves and washed hands in R11's sink, left room and went back to medication cart and prepped next resident's medication. On 7/29/25 at 1:20 PM, Surveyor interviewed LPN M who stated hand hygiene anytime you touch patients. Alcohol gel bothers me, I use wipes. On 7/30/25 at 1:15 PM, Surveyor interviewed LPN I, who stated hand hygiene should be performed anytime you work with a patient. LPN I stated, Yes medication administration you should wash hands before and after you are with patients. On 7/30/25 at 1:52 PM, Surveyor interviewed Director of Nursing (DON) B, who stated hand hygiene should occur anytime there is interaction with patients before and after. When asked for clarification, DON B stated yes, hand hygiene should occur taking blood pressures, preparing and passing medications, and assisting residents with eating. Example 2 The facility policy, titled Standard and Transmission-Based Precautions, reviewed 1/25, states: 11. Enhanced [NAME] Precautions. a. When required, Enhanced [NAME] precautions are used IN ADDITION to Standard Precautious. ii. Enhanced Barrier Precautions expands the use of PPE (personal protective equipment) and refer to the use of gown and gloves during high contact resident care activities. The use of gown and gloves for high-contact resident care activities is indicated, when Contact Precautions do not otherwise apply, for nursing home residents. 1. Examples of high contact resident care actives requiring gown and glove use for enhanced barrier precautions include: f. Device care of use: central line, urinary catheter, feeding tube, tracheostomy/ventilator. R5 was admitted to the facility on [DATE], and has diagnoses that include tetralogy of fallot, COPD, acute respiratory failure with hypoxia, macrocephaly, disturbances of salivary secretion, anxiety disorder and persistent mood affective disorder. R5 is a resident on enhanced barrier precautions (EBP) due to R5's health conditions and being on tube feedings. On 7/28/25 at 4:34 PM, Surveyor observed Nurse Tech (NT) J administer R5's tube feeding. NT J did not wear a gown during the tube feeding administrations. On 7/29/25 and 7/30/25, NT J not available to complete interview. On 7/30/25 at 1:15 PM, Surveyor interviewed Licensed Practical Nurse (LPN) I. Surveyor asked what (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	kind of personal protective equipment (PPE) should be used when providing or administering a tube feeding. LPN I stated both gown and gloves, maybe a mask. On 07/30/25 at 1:43 PM, Surveyor interviewed Director of Nursing (DON) B and asked expectation for infection control measures and PPE use while administering tube feeding. DON B indicated the expectation is that staff use good hand hygiene and utilize the PPE. DON B stated tube feeding residents are on EBP which includes gloves and gowns. Surveyor indicated that NT J was not observed wearing a gown while administering tube feeding. DON B stated NT J should have had a gown on. Example 3 Surveyor reviewed facility policy titled, Standard and Transmission-Based Precautions, dated revised on 02/2024, which stated in part, .Protocol: 1. Hand hygiene: d. Perform hand hygiene after removing gloves. 2. Gloves: d. Change gloves, as necessary, during the care of a resident to prevent cross contamination from one body site to another. f. Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces- and wash hands immediately to avoid transfer of microorganisms to other residents or environment. 11. Enhanced Barrier Precautions: ii. EBP expands the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. Examples of high-contact resident care activities are c. transferring, d. provide hygiene, and f. assisting with toileting. On 07/29/25 at 10:11 AM, Surveyor observed Certified Nursing Assistant (CNA) D and CNA F go into R1's room to transfer with EZ-Stand. CNA D and CNA F donned PPE appropriately. CNA D and CNA F hooked R1 up to EZ-Stand and lifted R1 up into the air. CNA D and CNA F placed R1 in the bathroom on toilet to use the restroom. CNA F stated, Ok I will set the timer and come back. CNA D and CNA F exited R1's room. On 07/29/25 at 10:22 AM, Surveyor observed CNA F go into R1's room to check on R1 in bathroom. CNA F decided to sit with R1 in bathroom and cleanse R1's nails. Surveyor observed CNA F squat and start cleaning underneath R1's nails getting debris and gunk from underneath R1's nails. CNA F stated, I know I should have PPE gown on. Surveyor observed CNA F continue cleaning out R1's nails without applying a gown. CNA F stood up and leaned over the EZ-Stand machine to clean R1's left hand fingernails out. Surveyor observed CNA F's scrubs touching EZ-Stand while R1 was sitting in the bathroom on toilet. CNA F finished cleaning R1's nails, washed hands, and exited room. On 07/29/25 at 10:38 AM, Surveyor observed CNA D and CNA F go into R1's room to get R1 off toilet. CNA D and CNA F donned PPE. Surveyor observed CNA D cleanse R1's bottom. CNA D stated, R1 is smearing so I need some extra wipes. Surveyor observed CNA D cleanse R1's bottom with wipes then CNA D grabbed unto EZ-Stand and helped CNA F push wheelchair to the side and EZ-Stand back out of bathroom with same contaminated gloves on. Surveyor observed CNA F push R1 in EZ-Stand with contaminated gloves until R1 reached the main area in room. CNA F then changed gloves once R1 was in main room near recliner. CNA F unhooked R1 from EZ-Stand and then parked EZ-Stand near R1's door. CNA D changed gloves and then began completing catheter care with emptying into graduate. CNA D cleansed tip of catheter drainage and then drained catheter into graduate. Surveyor did not observe CNA D sanitize hands between glove changes. Surveyor observed CNA F take EZ-Stand out of room and cleansed the EZ-Stand with wipe. Surveyor did not observe CNA F wipe down EZ-Stand sling. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/29/25 at 10:56AM, Surveyor interviewed CNA D and asked CNA D if CNA D and CNA F utilize the EZ-Stand for just R1 or is the EZ-Stand utilized between other residents. CNA D reported to Surveyor that CNA D uses the same EZ-Stand lift for all residents, but the lift is wiped down good. Surveyor indicated to CNA D that Surveyor observed CNA F wipe down the whole lift but not the sling that was used with R1 during toileting. CNA D reported to Surveyor that CNA D was taught by staff that the EZ-Stand sling can be used for all residents, so CNA D did not realize it was not ok. On 07/29/25 at 11:32 AM, Surveyor interviewed CNA D and asked about hand hygiene between glove changes. CNA D reported to Surveyor that CNA D should have sanitized hands in between glove changes from cleaning bowel movement off R1's bottom before changing gloves to perform catheter care. On 07/29/25 at 11:24 AM, Surveyor observed nursing student take contaminated EZ-Stand into R7's room to transfer R7. Surveyor did not observe sling to EZ-Stand be removed or sanitized. On 07/30/25 at 5:35 PM, Surveyor interviewed DON B and asked DON B what the expectation is of hand hygiene practices between glove changes. DON B reported to Surveyor that CNA D came to DON B and told DON B the issues with hand hygiene. DON B reported to Surveyor that DON B's expectation is that all staff complete hand hygiene such as sanitizing hands or washing hands if visibly soiled between glove changes. Surveyor asked DON B's expectation of CNA F wearing PPE in EBP room. DON B reported that in R1's room R1 is on EBP for Suprapubic catheter and with high touch cares. CNA F should have been wearing PPE. Surveyor asked DON B about the use of EZ-Stand sling with all residents. DON B reported that all slings should be wiped down before utilizing for other residents especially after an Enhanced Barrier Precaution (EBP) room. Example 4 R14 was admitted to the facility on [DATE] with current diagnosis of vascular dementia. R14's cognition is moderately impaired and requires maximum staff assistance for personal hygiene. On 07/29/25 at 9:28 AM, Surveyor observed Certified Nursing Assistant (CNA) G provide R14 personal cares. CNA G applied gloves, rolled R14 and pulled down pants. CNA G removed gloves and gathered a brief. CNA G washed hands appropriately and left room to gather cleansing wipes. CNA G returned applied gloves and removed R14's incontinence brief. CNA G used cleansing wipes to clean peri area. CNA G rolled R14 to the side and cleansed buttocks with the wipes. CNA G removed gloves, did not sanitize hands and applied clean gloves. CNA G applied a clean brief to R14, covered R14 with a blanket and attached the call light to R14. CNA G removed gloves, exited room and sanitized hands. On 07/29/25 at 11:32 AM, Surveyor interviewed CNA G about hand hygiene with glove change when providing R14 personal cares. CNA G stated she did not complete hand sanitization when she changed gloves. On 07/30/25 at 5:35 PM, Surveyor reviewed with DON B Surveyor's observation CNA G providing personal cares and no hand hygiene between glove changes.