STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525435	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Abbotsford Health Care Center	600 E Elm St Abbotsford, WI 54405

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 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. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility did not provide appropriate skin assessments and treatment by professional standards of practice to maintain a resident's highest practicable level of physical well-being for 2 of 2 residents (R2 and R3) reviewed.Staff did not assess and document R2's surgical incision on the left upper extremity. Staff did not complete a wound comprehensive assessment when R3 first developed the wound. This is evidenced by:R2 was admitted to the facility on [DATE] and discharged on 10/29/25. R2's current diagnoses include multiple fractures of pelvis with unstable disruption of pelvic ring, open wound left lower leg, traumatic subdural hemorrhage, fracture of the lower end of left radius, dislocation of left ulnohumeral joint, displace fracture of head of left radius, displace fracture of lateral epicondyle of left humerus, dislocation of right shoulder, fracture of body of sternum, contusion of lung, multiple fractures of ribs bilateral, pleural effusion, atelectasis, acute embolism, and acute pain.R2's Minimum Data Set (MDS) dated [DATE] admission assessment documented a Brief Interview for Mental Status (BIMS) score of 15/15 meaning intact cognition. Impairment to both sides of upper and lower extremities. Dependent with oral care, eating, toileting, shower/bathe, lower body dressing, personal hygiene, bed mobility. Maximum assist with upper body dressing. Resident did not transfer out of bed. R2 had surgical wounds.R2 had a surgical incision on 10/01/25 to the left upper extremity (LUE). On 10/13/25, R2 had a follow up appointment with physician and new orders, Steri strips can be peeled off at 3 weeks from surgery: 10/22/25. Call with any incisional concerns or drainage (phone number). Review of physician order dated 10/02/25 documented, LUE Incision/dressing. Keep clean and dry. Dressing to stay in place until next appointment. Two time a day for surgical wound. Note this order was not discontinued on 10/13/25 after R2's follow up appointment with the physician.Nursing progress note dated 10/25/25 documented R2 asked nurse to remove dressing from the LUE incision line as it was bleeding yesterday and upon examination a small area of the incision had partial dehiscence. The facility did not have documentation of assessments of the LUE surgical site or the removal of steri strips on 10/22/25. Note no prior documentation of assessments of the LUE surgical incision. Example 2R3 was admitted to the facility on [DATE]. R3's current diagnoses include non-pressure chronic ulcer of right lower leg with necrosis, type 2 diabetes mellitus with diabetic peripheral angiopathy, osteomyelitis, methicillin resistant staphylococcus aureus infection, bacteremia, depression, atherosclerotic heart disease, anxiety disorder, peripheral vascular disease, acquired absence of right leg below knee 5/12/25, and atrial fibrillation.MDS dated [DATE] a quarterly assessment documented a BIMS of 13/15, meaning cognition is intact. Impairment on one side of lower extremities. Dependent on staff for toileting hygiene, shower/bathe. Moderate assistance from staff with upper body dressing and maximum assistance with lower body dressing, personal hygiene, sit to stand, transfers. At risk for pressure injuries (PI) with no open PI and has a surgical wound.Nursing progress notes documented on 09/18/25 a skin condition non pressure assessment noted: Writer was completing Residents wound (treatment) tx to left great toe when Resident c/o pain when writer began to wrap left foot with kerlix. Upon evaluation Residents heel was non-blanchable and had red area to left heel. Resident state he does not move his left foot or re-position throughout the day unless he sits up to eat meals. Heel was cleansed and covered with border foam. Resident was encouraged to re-position foot and continue to wear protective boot. DON notified, wound nurse to evaluate on tx day. Order for air mattress and temporary tx was placed. Note, this was not a complete assessment to include size. R3 was seen at the vascular clinic on 09/19/25 noting a pressure ulcer on the left heel. Nonpalpable left pedal pulses. Critical limb ischemia of left lower extremity with a plan to have a left lower extremity angiogram with possible intervention.The next facility wound assessment was completed on 09/30/25 of a left heel pressure stage 1 measuring 1.5 cm x 1 cm. Facility provided a weekly wound evaluation dated 12/02/25 documenting the pressure injury to the heel as a vascular wound. On 12/10/25 at 3:50PM, Surveyor interviewed Director of Nursing (DON) B about assessments of wounds for R2 and R3. DON B stated did not have documented assessments of R2's LUE surgical incision site. Could not find the initial assessment of measurements when first found R3's heel wound.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - 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 interview and record review, facility did not implement professional standards of practice to ensure that a resident does not develop pressure injuries (PIs), receives necessary treatment and services to promote healing and prevent new PIs from developing for 1 of 1 resident (R) reviewed. (R4)R4 was admitted to the facility with an unstageable pressure injury to left heel. Staff did not complete a comprehensive PI assessment to include measurements and description of the PI. This is evidenced by:R4 was admitted to the facility on [DATE]. R4's current diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, methicillin resistant staphylococcus aureus infection 11/12/24 and 3/20/25, pressure induced deep tissue damage of left heel, type 2 diabetes mellitus without complications, protein-calorie malnutrition, atrial fibrillation, chronic kidney disease stage 3A, anxiety disorder, and depression.R4's Minimum Data Set (MDS) dated [DATE] admission 5 day assessment documented BIMS score of 15, meaning intact cognition. Impairment to one side of upper extremity. Moderate assistance needed from staff for oral care, personal hygiene, bed mobility. Maximum assistance for upper body dressing and is dependent on staff for toileting hygiene, shower/bathe, lower body dressing, and transfers. R4 is at risk for PI with one unstageable PI on admission.R4's admission clinical assessment completed on 11/07/25 documented a skin issue of a pressure ulcer/injury that is unstageable and present on admission. This assessment did not include measurements and description of the PI.The first assessment was completed by the wound clinic on 11/11/25 documenting 11/11/25 Pt know to wound care team. Pu to the Lt heel is now a reoccur. Stage 3 0.5 cm x 2 cm x 0.2 cm, small serous exudate and tissue type is 100% granulation.On 12/10/25 at 3:50PM, Surveyor interviewed Director of Nursing (DON) B about assessments of PI on admission for R4. DON B stated did not have documented admission assessment of R4's PI to include measurements and description of the PI. Surveyor asked DON B if the expectation is to complete a comprehensive assessment of the PI on admission. DON B stated yes, there should be a complete assessment of the PI.