

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/10/2024
NAME OF PROVIDER OR SUPPLIER  Meadowbrook at Black River Falls		STREET ADDRESS, CITY, STATE, ZIP CODE  1311 Tyler St Black River Falls, WI 54615	

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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16692</b></p> <p>Based on interview and record review, the facility did not ensure that 2 of 3 residents (R1 and R6) at high risk for pressure ulcer development, received the necessary treatment and services needed to prevent the development of a pressure injury.</p> <p>R1 was admitted to the facility with a brace and ace bandage on her leg. R1 was identified as being at risk for pressure injuries and a care plan was not developed. The facility did not assess the skin under the brace/ace bandage routinely, which lead to multiple pressure injuries. The pressure injuries became infected, which required R1 to be hospitalized and have a surgical procedure and antibiotics.</p> <p>Facility failure to assess R1's skin under her brace/ace bandage routinely led to the development of multiple pressure injuries which created a finding of immediate jeopardy that began on 05/15/24. Surveyor notified Nursing Home Administrator of the immediate jeopardy on 07/03/24 at 1:20 p.m. The immediate jeopardy was removed on 07/05/24. However, the deficient practice continues at a scope/severity level of D (potential for more than minimal harm/isolated) as the facility continues to implement its action plan and as evidenced by:</p> <p>The facility did not follow R6's plan of care of placement of a right heel cup to prevent the redevelopment of a pressure injury.</p> <p>This is evidenced by:</p> <p>Example 1:</p> <p>The facility policy entitled, Pressure injury Prevention Guidelines, dated 2022, states in part: Inspect skin underneath medical devices at least twice daily. Keep skin clean and dry underneath. Adjust the device as needed for proper fit.</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 National Pressure Injury Advisory Panel prevention and treatment of pressure ulcers/injuries quick reference guide 2019 recommendations for device related pressure injuries: Assess the skin under and around medical devices for signs of pressure related injury as part of routine skin assessment. Reduce and/or redistribute pressure at the skin-device interface by regularly rotating or repositioning the medical device and/or the individual. Providing physical support for medical devices in order to minimize pressure and shear. Removing medical devices as soon as medically feasible. Provide high-calorie, high-protein, arginine, zinc and antioxidant oral nutritional supplements or enteral formula for adults with a category/Stage II or greater pressure injury who are malnourished or at risk of malnutrition.</p> <p>R1 was admitted to the facility on [DATE] and has diagnoses that include displaced fracture of the right ulna, fracture right tibia, right tibial plateau fracture repair, falls, subdural hematoma, weakness, atrial fibrillation, and lymphedema.</p> <p>Hospital discharge instructions included tibial plateau fracture repair. Keep cast/splint clean and dry. Weight bearing instructions right lower extremity: toe touch weight bearing. Follow up in 2 weeks for wound check, staple removal. The facility did not clarify discharge instructions for removal of leg brace.</p> <p>04/18/24 Braden states - bedfast resident is completely immobile does not make even slight changes in body or extremity position without assistance .Braden score 12 High Risk. Additional clinical suggestions: is left blank.</p> <p>Minimum Data Set (MDS) 5 day admission assessment, dated 04/24/24, documented a brief interview of mental status score of 13, cognitively intact. The MDS documents R1 as being dependent on staff for bed mobility and transfers, at risk for pressure injuries and no current pressure injuries. The MDS did not document pressure reducing devices, no turning repositioning program, and no nutritional or hydration interventions were utilized.</p> <p>R1's care plan on admission does not mention skin. No interventions are listed or put into place on the plan of care in relation to skin or prevention of pressure injuries throughout the resident's stay. The initial and final care plans for R1 read the same.</p> <p>Resident has limited physical mobility.</p> <p>Goal: Resident will increase level of mobility through next review, approaches approach resident offer assistance to the bathroom every 2-3 hours around the clock. Per resident please wake up every 2-3 hours to offer bathroom assistance - 2 assist with full body lift.</p> <p>Resident experiences isolation due to being non weight bearing and fear of the hoyer resident will express feelings of around loneliness and isolation when she feels them. Encourage resident to express feelings.</p> <p>R1's treatment administration record (TAR) for April states, Keep cast/splint dry three times a day - this is initialed three times daily, beginning on April 19. Weight bearing instructions: RLE [Right lower extremity], to [should be toe] touch weight bearing, every shift - this is initialed three times a day beginning on April 18.</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>Pressure injury 2, Right inner thigh, middle area, length 6.5 cm by width 7.8 cm depth 0 - deep tissue Pressure injury - skin closed, necrotic tissue present 100% deep purple, almost black necrotic tissue noted, almost like blood blister, no open areas. plan/treatment - monitor on TAR until healed. Assess for signs and symptoms of infection. Interventions - nutrition or hydration intervention to manage skin problems.</p> <p>Pressure injury 3, Right inner thigh, most inferior of three areas, length 1.5 cm by width 9 cm depth 0 Deep Tissue Pressure Injury- skin closed necrotic tissue present - dark purple, almost black, appears to be blood blister or necrotic area from improperly applied ace bandage no open areas. plan/treatment - monitor on TAR until healed. Assess for signs and symptoms of infection. Interventions - nutrition or hydration intervention to manage skin problems.</p> <p>Physician notification form dated 05/15/24 notes 3 areas of concern on her inner right thigh.</p> <ol style="list-style-type: none"> <li>1. Measures 11.3 cm x 1.4 cm</li> <li>2. Measures 6.5 cm x 7.8 cm</li> <li>3. Measures 9 cm x 1.5 cm</li> </ol> <p>All areas are dark purple/black, appear to be necrotic areas from ace bandage. Peri-wound area is red, but blanchable. Resident reports burning and pain when touching area. Lotion was applied and ace wrap re-wrapped.</p> <p>MD responded to notification on 05/30/24: Evaluated today will likely need debridement but recommend eval and treat by wound care center and nursing. Keep ace wrap/tubi grips off wound area, Finish ABX last day today. (This antibiotic began on 05/24/24) Continue Tylenol prn for pain.</p> <p>Clinic note, dated 05/16/24, a fax message from the facility to clinic: 3 areas of concern on her inner thigh measuring 11.3 x 1.4 cm, 6.5 cm x 7.8 cm, 9 cm x 1.5 cm. All areas are dark purple/black appear to be necrotic areas from Ace bandage. Physician Assistant (PA) I requested more information about the areas from the facility.</p> <p>05/16/24 Progress Notes - Right lower leg: Brace in place</p> <p>Clinic note, dated 05/17/24, telephone message from License Practical Nurse (LPN) D to the clinic. Discolored spot update. Right leg looks more like a bruise behind right knee. Area is not open, just bruised, no blisters, not necrotic. Painful to touch .looks like the brace was rubbing causing pressure in this area. Patient wanting to stay in bed due to the hoier lift straps rub/sit on the sore, bruised area. PA I responded to continue with efforts to offload pressure at the site.</p> <p>Clinic note, dated 05/23/24, message from Medical Doctor (MD) J to facility: Possible cellulitis. She had an abrasion to her right upper leg and developed some surrounding redness, tenderness, induration. Appears to be a cellulitis. Empiric antibiotic recommended. Escalate therapy to clinic or emergency department visit if worsening. MD J ordered to start Cephalexin Capsule 500 mg every 6 hours for 7 days.</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 07/02/24 at 4:15 PM, Surveyor interviewed LPN D and Registered Nurse (RN) E. LPN D stated that staff was not looking at skin underneath the brace/ace bandage and did not remove the brace or ace bandage until after receiving an order that the brace could be removed on 05/03/24. LPN D stated that she was not shown or taught how to remove the immobilizer brace. RN E stated that the last two weeks of May the brace was off. LPN D stated the resident would refuse to have the brace removed. Surveyor's review of documentation revealed this was rarely documented.</p> <p>Surveyor asked what interventions were put into place to prevent R1's pressure injuries. RN E indicated R1 had a full pressure reduction bariatric air mattress in place and used pillows for repositioning.</p> <p>LPN D stated at times she used a rolled-up towel between R1's legs. They indicated R1 had a Roho cushion in her wheelchair, but she rarely got out of bed. RN E stated they started the Juven supplement (a nutritional supplement used to aid in healing) on 06/04/24.</p> <p>On 07/02/24 at 6:50 PM, Surveyor interviewed Nursing Home Administrator (NHA) B who stated a skin assessment should have been done on admission, including looking at the skin underneath the brace and ace bandage. When asked if skin under braces and ace bandages should be inspected routinely, NHA B stated, Yes.</p> <p>On 07/03/24 at 12:55 PM, Surveyor interviewed MD F who stated she first saw R1's wounds on 05/30/24, to the best of her recollection. Surveyor asked if she was aware the facility had not been inspecting R1's skin under the brace and ace bandage. MD F stated she was not aware one way or the other. Surveyor asked if R1's wounds would have been preventable if facility staff were removing the ace bandage and brace and assessing R1's skin. MD F stated probably.</p> <p>The failure to put measures in place to prevent the development of a pressure injury and to promote the healing of pressure injuries created a reasonable likelihood of serious harm which led to a finding of immediate jeopardy that began on 05/15/24. The facility removed the immediate jeopardy on 07/05/24 when it had completed the following:</p> <ol style="list-style-type: none"> <li>1. Provide education to all nursing staff on skin policies and procedures, including admission [NAME] assessments, and implementing orders to check skin under medical devices daily for signs of pressure related injuries, and timely updates with new skin issues/breakdown with orders obtained and care plans updated.</li> <li>2. Provide education to the Interdisciplinary Team (IDT) on new admission review to ensure skin assessments are completed and schedule is in place in the treatment administration record (TAR) to check under any medical device daily for signs of pressure related injuries.</li> <li>3. Provide education to all nursing staff, minimum data set (MDS) coordinator, and IDT on ensuring care plans with specific interventions are implemented for all residents at risk of developing pressure injuries. Education including review of care plans, evaluations of effectiveness of interventions, and addition of new interventions if needed.</li> </ol> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Meadowbrook at Black River Falls		STREET ADDRESS, CITY, STATE, ZIP CODE  1311 Tyler St Black River Falls, WI 54615	
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>4. Perform a facility-wide skin sweep by 07/05/24 to ensure all residents at risk for pressure injuries have care planned interventions, all current skin conditions are documented and on the weekly wound tracking document, and any new skin concerns are identified, and the physician and resident's power of attorney (POA) if applicable are updated with orders obtained and care plan updates are made.</p> <p>5. Director of Nursing (DON)/designee will conduct new admission audits daily to ensure orders are in place to check under medical devices for those utilizing x 4 weeks, then weekly x 4 weeks.</p> <p>6. DON designee will conduct weekly audits x 4 weeks, then bi-weekly x 4 weeks, of resident care plans to endure interventions are in place and effective for those at risk for pressure injuries.</p> <p>7. Medical devices added to IDT daily clinical board to ensure orders in place for skin monitoring.</p> <p>8. The results of all audits will be brought to monthly quality assurance performance improvement (QAPI) meeting to determine effectiveness and if additional audits or education are needed.</p> <p>Example 2:</p> <p>R6 was admitted to the facility on [DATE] with unspecified dementia, type 2 diabetes, and failure to thrive.</p> <p>R6's care plan dated 01/12/24 states, The resident is at risk for pressure injury r/t (related to) decreased mobility, muscle weakness, and presents of pressure ulcer.</p> <p>On 04/05/24, R6 received an order for R (right) Heel cup to right heel at all times for pressure relief. Check for placement each shift.</p> <p>On 07/05/24, facility updated order to continue R heel cup to right heel at all times for pressure relief. Check placement each shift.</p> <p>On 07/10/24, Surveyor reviewed Treatment Administration Record (TAR) which was signed off each shift during the month of July 2024 of having R heel cup in place.</p> <p>On 07/10/24 at 1:15 PM, Surveyor was unable to visualize R heel cup as resident was wearing shoes.</p> <p>On 07/10/24 at 1:30 PM, Surveyor interviewed Certified Nursing Assistant (CNA) G regarding the R heel cup for R6. CNA G stated not recalling the last time she had seen the heel cup as the area is healed.</p> <p>On 07/10/24 at 1:45 PM, Surveyor interviewed LPN D regarding the R heel cup. LPN D stated R6 has been getting out of bed more lately and has not been wearing the heel cup as he is wearing shoes. LPN D stated would contact hospice to have discontinued.</p> <p>On 07/10/24 at 1:50 PM, Surveyor interviewed RN H, who indicated the order for heel cup has been discontinued.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Meadowbrook at Black River Falls		STREET ADDRESS, CITY, STATE, ZIP CODE  1311 Tyler St Black River Falls, WI 54615	
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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 07/11/24 at 5:56 AM, Surveyor received further information from RN H, indicating R heel wasn't a true DTI, but a discolored area. The order for the heel cup was put in place, and then three weeks ago R6 started getting up more, going outside more and wearing shoes. The heel cup needed to be taken off when wearing shoes. The facility failed to adjust the order to read wear the heel cup when in bed with his heel boots.</p>		