

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525494	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2026
NAME OF PROVIDER OR SUPPLIER Serenity Spring Senior Living at Scandia Village		STREET ADDRESS, CITY, STATE, ZIP CODE 10560 Applewood Rd Sister Bay, WI 54234	
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure physician recommendations were followed for 1 resident (R) (R5) of 1 sampled resident from a total sample of 5 residents. R5 did not receive physician recommended shoes to aid in wound healing. In addition, staff did not monitor R5 for factitious disorder/picking behaviors to prevent further foot trauma. Findings include: The facility's Prevention of Pressure Injuries policy, revised June 2023, indicates: .Do not rub or otherwise cause friction on skin that is at risk for pressure injuries. The facility's Pressure Ulcers/Skin Breakdown policy, revised January 2026, indicates: .The physician will help identify factors contributing or predisposing residents to skin breakdown; for example, medical comorbidities such as .macerated or friable skin .The physician will help identify medical interventions related to wound management .The physician will guide the care plan as appropriate .Current approaches should be reviewed for whether they remain pertinent to the resident's medical conditions, are affected by factors influencing wound development or healing, and the impact of specific treatment choices made by the resident or a substitute decision-maker. Per the National Library of Medicine, last updated June 17, 2026, Venous Leg Ulcer authored by [NAME]-[NAME], [NAME] Jaar, and [NAME] Kimyaghalam indicates arterial ulcers, caused by tissue ischemia, normally appear as deep, dry wounds affecting the toes, foot dorsum, and the anterior aspect of the leg, with abnormal distal pulses, ABPI, and cold extremities. https://www.ncbi.nlm.nih.gov/books/NBK567802/R5 had a diagnosis of Parkinson's disease. A Minimum Data Set (MDS) assessment, dated 4/14/26, indicated R5 was at risk for pressure injuries but did not have any skin injury/concerns. The assessment also indicated R5 had moderately impaired cognition. A facility-provided resident matrix indicated R5 had a pressure injury. R5's medical record contained the following weekly wound assessments of the right hallux (bunion): ~ An assessment on 5/18/26 described the area as a pressure injury (not staged) that measured 0.9 centimeters (cm) (length) x 0.9 cm (width) x 0.1 cm (depth). The physician was notified. Treatment was initiated, including an antibiotic. The assessment indicated R5's shoes appeared to be rubbing and they agreed to wear gripper socks until the area was healed. ~ An assessment on 5/26/26 described the wound as a pressure injury (not staged) that measured 0.7 cm x 0.8 cm with no depth and scant serosanguinous drainage. ~ An assessment on 6/2/26 described the wound as a pressure injury (not staged) that measured 0.7 cm x 0.9 cm with no depth and no drainage. The area was firm with no redness. The assessment indicated R5 no longer wore shoes that fit too tightly and mostly wore grippy socks. ~ An assessment on 6/9/26 described the wound as a pressure injury (not staged) that measured 0.7 cm x 0.8 cm with no depth and no drainage. ~ An assessment on 6/19/26 indicated the wound was arterial and measured 1.2 cm x 1 cm x 0.1 cm, with low serous drainage and autolysis. The wound size was expected to increase. Compression wraps were in place. ~ An assessment on 6/23/26 indicated the wound was arterial and measured 0.5 cm x 0.7 cm x 0.1 cm with low clear drainage. Compression (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	wraps were in place. ~ An assessment on 6/30/26 indicated the wound was arterial and measured 0.5 cm x 0.8 cm x 0.1 cm with low clear drainage. Compression wraps were in place. ~ An assessment on 7/7/26 indicated the wound was arterial and measured 0.7 cm x 0.7 cm x 0.1 cm with low clear drainage and epibole (sign that healing has stalled or become impaired). Redness extended approximately 2 cm beyond the wound edge and was painful to the touch. Compression wraps were in place. The assessment indicated staff would contact the wound clinic regarding the pain and redness. ~ An assessment on 7/13/26 indicated the wound was arterial and measured 0.6 cm x 0.7 cm x 0.1 cm with moderate clear drainage. A second assessment on the same day indicated the wound was trauma and measured 0.6 cm x 0.7 cm x 0.1 cm with moderate clear drainage. A wound center note on 7/13/26 indicated the etiology of R5's ulcers were uncertain. The note indicated some of wounds may be due to factitious disorder/picking behavior or from traumatic injuries as a result of R5 self-propelling a wheelchair. The lesions on the toes and foot were on pressure points/prominent bony surfaces suggesting friction from footwear that may be too tight. The note indicated R5 should not be allowed to wear shoes until the wounds completely healed. Shoes worn after the wounds healed should be properly sized with a wide toebox. Given the suspicion regarding factitious disorder/picking behavior, R5 should be monitored. An undated skin integrity care plan printed on 7/16/26 indicated R5 had actual impairment to skin integrity related to a history of pressure ulcers and had the potential for further pressure ulcer development related to immobility and incontinence. R5 should be encouraged to wear grippy socks but preferred tennis shoes and grippy socks. R5 should avoid scratching by keeping hands and body parts from excessive moisture and fingernails short. The care plan also indicated R5 was at high risk for skin injury and staff should use extra caution during transfers and bed mobility to prevent striking R5's arms, legs, and hands against sharp or hard surfaces. An undated activity of daily living (ADL) care plan printed on 7/16/26 indicated R5 required physical assistance with transfers. The care plan did not indicate R5 had factitious disorder/picking behavior or that R5 injured or had the potential to injure themselves by self-propelling a wheelchair. The care plan did not contain monitoring interventions for factitious disorder/picking behavior. On 7/16/26 at approximately 11:30 AM, Surveyor interviewed R5 who was wearing shoes and socks. R5 stated the shoes could have caused their bunion and indicated the right shoe was tighter than the left shoe. Surveyor observed a bunion bulging from the side of R5's right shoe. On 7/16/26 at 2:52 PM, Surveyor interviewed wound clinic Advanced Practice Nurse Practitioner (APNP)-E who stated the wound clinic was not calling R5's wound a pressure injury because it was clear that while the injury was on a bony prominence, the injury was caused from shoes or the bed rubbing on the area. APNP-E stated R5 should definitely not be wearing shoes. On 7/16/26 at 3:10 PM, Surveyor and Wound Nurse Consultant (WNC)-D observed R5 in their room. WNC-D confirmed R5 was wearing shoes. WNC-D removed the shoes, put socks on R5, and stated, We do not want to have pressure at the end of those toes. Surveyor pointed out an area on the top of R5's foot where the edge of the shoe had been and where the skin was peeled back. On 7/16/26 at 4:04 PM, Surveyor interviewed WNC-D who stated R5's right bunion was an arterial wound, not a pressure injury. WNC-D stated the bunion could have resulted from light friction or being bumped, but the etiology was unknown. WNC-D stated R5's shoes seemed okay but removed them because the wound clinic suggested they not wear shoes. When Surveyor asked about the wound clinic's recommendation that R5 have shoes that were properly sized with a large toebox, WNC-D did not know if R5's shoes were properly fitted and did not know how to measure them for a large toebox. WNC-D contacted the wound clinic for instructions on how to ensure R5 had shoes that were properly fitted. On 7/16/26 at 4:06 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-F who stated R5 had a different pair of shoes that R5 stated rubbed on their toes. LPN-F (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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