STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525531	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Christian Home LLC	452 Fox Lake Road Waupun, WI 53963

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 - 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 that residents received treatment and care in accordance with professional standards of practice for 3 of 5 residents (R5, R4, and R2) reviewed. R5 developed a blister to their right heel. The facility failed to complete diabetic foot checks, complete a full wound assessment, and update the physician timely. The facility failed to ensure proper skin assessment and wound measurements were completed at the time of admission for R2 R4 complained of not feeling well and had an emesis. Facility did not perform an assessment. R4 was hospitalized the following day due to noted change of condition and admitted with urinary tract infection. Evidenced by: The article Diabetic foot ulcer: A comprehensive review of pathophysiology and management modalities dated 3/16/23 states in part, .Diabetic foot ulcer (DFU) is a debilitating and severe manifestation of uncontrolled and prolonged diabetes that presents as ulceration, usually located on the plantar aspect of the foot. Approximately 15% of individuals with diabetes will eventually develop DFU, and 14%-24% of them will require amputation of the ulcerated foot due to bone infection or other ulcer-related complications. The pathologic mechanisms underlying DFU are comprise a triad: Neuropathy, vascular insufficiency, and secondary infection due to trauma of the foot. Preventative care: Due to diabetes being a risk factor for the development of underlying peripheral vascular disease, the majority of DFUs are asymptomatic until advanced enough to recognize more severe signs and symptoms. During the diagnosis of DFU, neuropathy may mask ischemia and vice versa. Therefore, the primary preventative strategy is regular diabetic foot screening to allow early identification of DFU, followed by initiation of treatment if appropriate. Ultimately, early detection and management work to avoid further complications such as gangrene and amputation. Diabetic foot ulcer: A comprehensive review of pathophysiology and management modalities - PMC The facility's policy titled Pressure Injury Prevention and Management dated 2/2025 states in part .c. Wound assessments will be documented in the medical record. Findings should include type of wound, wound measurements (measured upon discovery, and at least weekly thereafter), other wound characteristics (color, exudate, pain, tissue type in wound bed), and treatment and interventions implemented. Surveyor requested a policy for non-pressure wounds, and none was provided. (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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(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 - Actual harm Residents Affected - Few	Example 1 R5 was admitted to the facility on [DATE] with diagnoses that include posterior displaced type 2 Dens fracture (fracture is a break that occurs through a specific part of C2, the second bone in the neck), type 2 diabetes mellitus, and peripheral vascular disease (a common condition in which narrowed arteries reduce blood flow to the arms or legs). R5's most recent MDS (Minimum Data Set) dated 3/2/26 states that R5 has a BIMS (Brief Interview of Mental Status) of 15 out of 15, indicating that R5 is cognitively intact. R5's care plan dated 2/25/26 states in part: Focus: Skin Integrity: At risk /and/or potential for complications with impaired skin integrity including skin tears, bruising, and/or pressure r/t (related to) current medical/physical status. Has meds/dx (diagnosis) that can/may affect skin integrity. Stage 3 to sacrum, non-pressure to R (right) heel, unstageable to back of head, venous wound to right calf tx (treatment) per wound MD (Medical Doctor) order (Revision on 4/14/2026) .Interventions/Tasks: Assist/encourage pressure relief as needed/accepted. Follow community skin protocol. Observe skin with AM/PM (morning/evening) cares and with toileting for redness, rashes, open areas, pain, swelling and report them to team leader. Weekly skin check. Lotion to dry skin. Review skin concerns with MD. Of note, Surveyor reviewed R5's MD orders and there is no order for diabetic foot checks. Facility did not provide evidence to show nursing staff were checking R5's feet daily from admission on [DATE] through 3/15/26. On 3/15/26 at 8:49 PM R5's nurses note indicates: Resident has a 2cm (centimeter) x 5cm blister that peeled back to right outer heel. Cleansed and applied Mepilex to cover and protect until provider assesses and gives order. Note to provider put in folder. (of note: R5's provider was not updated timely with a new wound, treatment orders were not obtained and there is not a comprehensive assessment documented upon discovering R5's heel wound.) On 3/17/26 at 11:37 AM R5's nurses note indicates: [Nurse Practitioner's Initials] here and gave referral for the wound doctor to see resident's right heel, also gave resident referral to have a vascular consult if indicated. It is important to note that there is no documentation stating that wound care was provided between 3/16/26- 3/18/26. Diabetic foot checks still were not being implemented after discovering a wound on R5's heel. On 3/18/26 at 12:35 AM R5's nurses note indicates: Resident going to [Health Care Facility] for a doctor appointment with his son. Resident concerned about his circulation. On 3/18/26 at 4:25 PM R5's nurses note indicates: [MD (Medical Doctor) name] wound MD was here for rounds see documents for notes, measurements, and any new orders of this weeks visit.Resident went to [Health Care Facility] for wound that opened on R (right) heel and res (resident) forgot to give paperwork to MD so no paperwork came back. He refused to have wound MD look at the area d/t (due to) it being all dressed from the clinic. Writer tried to call [Health Care Facility] and it had already closed and will try in the morning for wound orders. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 3/18/26 at 1:30 PM R5 went to an outside provider for wound care. Wound care Nurse Practitioner's note states in part .Right foot wound: [R5's name] indicates he had been self-propelling his wheelchair at the [Facility's Name] with his right foot (despite knowing better). SNF (Skilled Nursing Facility) applied dressing/gauze overwrap 2 nights ago, has not been checked since then. Right foot is causing pain/burning at night; + (positive) serosang (serosanguinous (thin, watery fluid that contains a small amount of blood mixed with serum)) drainage, not malodorous.Physical exam: .Skin: R lateral heel: 4.4cm x3cm partially de-roofed bullae (the skin (roof) has either rubbed off or been removed). + serosanguinous drainage. Wound cleansed, Aquacel Ag and Allevyn dressing applied. It is important to note that the facility obtained this visit note on 4/15/26. The clinic notes R5's wound has not been attended to in the last 2 nights. On 3/19/26 at 10:47 AM, the facility received a faxed order from R5's visit on 3/18/26. The order states: Wound Care: Cleansed right lateral heel with anasept and gauze. Skin prep applied to peri wound. Cut aquacel AG to wound size and applied directly over wound bed, followed by bordered foam dressing. Additional supplies provided. May cleanse with soapy water and change every 2-3 days. (of note: this treatment order was received 4 days after the wound was discovered) Wound MD note on 3/25/26 states in part: .Non-Pressure Wound of the Right Heel Full Thickness: Etiology (quality): Neuropathy Further etiology detail: spinal disease, complicated by BLE (bilateral lower extremity) edema.Wound size (L (length) x W (width) x D (depth)): 7.7 x 7.3 x 0.2 cm (centimeters).Exudate: Heavy Serous (a clear or pale yellow, thin, watery fluid that naturally leaks from a wound)Thick adherent devitalized necrotic tissue: 10%. Granulation tissue: 90%. Additional Wound Detail: Ruptured blister of lateral right heel. Neuropathy from Spina Biffida occulta along with CHF (Congestive Heart Failure) edema and Charcot arthropathy of foot. Has been seeing [Health Care Facility name] wound clinic for this episodic issue up through last week. (of note: R5's heel wound is noted to be larger on 3/25/26, than it was on 3/18/26. The wound now has 10% necrotic tissue present) Wound MD note on 4/1/26 states in part: .Non-Pressure Wound of the Right Heel Full Thickness: Etiology (quality): Neuropathy Further etiology detail: spinal disease, complicated by BLE edema. Wound size (L x W x D): 7.7 x 7.4 x 0.2 cm .Periwound radius: maceration. Exudate: Heavy Serous. Thick adherent devitalized necrotic tissue: 30%. Slough: 10% Granulation tissue: 60% . Additional wound detail: Med team started on Doxycycline (antibiotic) when diuretic was doubled. Evidence now of moderate extensive RLE (right lower extremity) edema to just above knee and maceration but no purulence (pus) or erythema (redness of the skin) at this time.Surgical Excisional Debridement Procedure: Indication for procedure: Remove necrotic tissue and establish margins of viable tissue.Procedure note: The wound was cleansed with normal saline and anesthesia was achieved using topical benzocaine. Then with clean surgical technique, 15 blade was used to surgically excise 17.09 cm of devitalized tissue and necrotic subcutaneous level tissues along with slough and biofilm were removed at a depth on 0.2cm and healthy bleeding tissue was observed. As a result of this procedure, the nonviable tissue in the wound bed decreased for 40% to 10% . (of note: R5's wound had 40% necrotic tissue compared to 10% necrotic tissue on 3/25/26) Wound MD note on 4/8/26 states in part: .Non-Pressure Wound of the Right Heel Full Thickness: Etiology (quality): Neuropathy Further etiology detail: spinal disease, complicated by BLE (bilateral (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	lower extremity) edema. Wound size (L x W x D): 4.8 x 6.5 x no measurable cm. Depth is unmeasurable due to presence of nonviable tissue and necrosis. Exudate: Moderate sero-sanguinous (pinkish yellow drainage). Thick adherent black necrotic tissue (eschar): 70% Thick adherent devitalized necrotic tissue: 10%. Granulation tissue: 20% . Additional wound detail: Reduces surface area but increased heel eschar.Sharp Selective Debridement Procedure: Indication for procedure: Removal of devitalized epidermis and/or dermis. Remove dried exudates or debris.Procedure note: The wound was cleansed with normal saline and anesthesia, though not required, was achieved using topical benzocaine. Then with clean surgical technique, 15 blade was used to selectively remove devitalized epidermis and/or dermis, remove dried exudates or debris over the wound surface area of 31.2cm. On 4/14/26 at 9:56 AM, Surveyor observed wound care with RN H (Registered Nurse) and LPN I (Licensed Practical Nurse). Surveyor observed R5's right heel wound bed to be necrotic and appeared to look like a cap. The wound was approximately 2 x 3. R5 reported to Surveyor that they haven't been able to wear shoes for about 6 weeks due to them causing too much pain. It is important to know that Surveyor requested documentation of daily diabetic foot checks from 2/10/26 through 4/14/26, and none were provided. On 4/14/26 at 2:10 PM, Surveyor interviewed RN H. Surveyor asked RN H how often staff are completing diabetic foot checks, RN H reported that they are putting the order in to complete them daily. Surveyor asked RN H how often they were being completed prior to today, RN H stated they were being done weekly with their bath. Surveyor asked RN H where they chart weekly skin checks, RN H stated they are on the MAR/TAR (Medication Administration Record/ Treatment Administration Record) and that there is an assessment for weekly wound check/weekly skin check. Surveyor asked RN H if they complete the weekly skin check assessment weekly, RN H stated that they will be completing that from now on. On 4/14/26 at 2:21 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B if the facility has a wound nurse, DON B stated it was LPN I. Surveyor asked DON B if LPN I was wound care certified, DON B stated no. Surveyor asked DON B what the expectation was for nursing staff and the completion of weekly skin checks, DON B stated they should be completed weekly on bath day. Surveyor asked DON B if they should be documented, DON B stated yes. Surveyor asked DON B how often diabetic foot checks should be completed, DON B stated daily. Surveyor asked if diabetic foot checks should be documented, DON B stated they should be documenting them on the TAR. DON B reviewed R5's TAR, and no order for diabetic foot checks was found on R5's TAR. DON B reported that staff are doing daily wound care and are looking at both of R5's feet at that time. Surveyor reported that during wound care observation, R5's right foot was the only foot exposed. On 4/15/26 at 1:35 PM, Surveyor interviewed LPN I. Surveyor asked LPN I if facility staff completed a wound assessment when R5's wound was first observed, LPN I stated that the nurse who found it measured the length and width. Surveyor asked LPN I if that was a complete assessment, LPN I stated no. Surveyor asked LPN I who is responsible for assessing wounds from the onset until the wound MD can see them, LPN I stated the nurses monitor the wounds. LPN I reported that if a resident has a pressure injury, they will look at the wound and determine a plan. Surveyor asked LPN I what the facility's policy is regarding wound assessments, LPN I stated that they look at the wound, measure it, update the MD, and put a plan in place. LPN I reported that R5 obtained their wound on a Sunday and they were not aware of the wound until Tuesday, and then R5 refused treatment by the wound MD on Wednesday due to seeing an outside provider. Surveyor asked LPN I if R5's wound was assessed on Monday, LPN I stated no and that R5 refused. Surveyor asked if R5's refusal was (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	documented, LPN I stated no. Surveyor asked LPN I if nursing staff completed a complete assessment of R5's wound between Sunday and Wednesday, LPN I stated no. Surveyor asked LPN I if they would expect staff to call the on-call MD versus faxing or leaving a note in the MD's folder, LPN I stated yes. On 4/15/26 at 3:33 PM, Surveyor interviewed MD J (Medical Doctor). Surveyor asked MD J if they would expect staff to complete daily diabetic foot checks, MD J stated yes. Surveyor asked MD J about the etiology of R5's right heel wound and that documentation indicated that it started as a blister, MD J stated that the wound may be venous and that R5 lays on that side. R5 was at risk for skin concerns due to his diagnosis of diabetes, staff did not perform daily diabetic foot checks, resulting in R5 being found with a heel wound, that was not assessed upon discovery and deteriorated prior to being seen by the wound physician. Example 2: R2 was admitted to the facility on [DATE] with a diagnoses including diabetes, pulmonary disease, acute kidney failure, muscle wasting, chronic venous hypertension (high pressure in leg veins due to damaged or weak valves causing chronic leg swelling), heart failure, cellulitis of right lower limb, atrial fibrillation, and cardiac pacemaker. R2's skin assessment at time of admission states,.9/15/26, resident has blisters on RLE related to cellulitis. Treatment from hospital on admission placed already on RLE was oil emulsion to blisters, covered by abd pads, wrapped in kerlix. After supper, dressing saturated with drainage. Cleansed with saline and dressings reapplied. R2's Right big toe wound was not assessed, measured or documented on upon admission by facility staff. R2's hospital discharge paperwork indicated that R2 also had a wound on base of the big toe right side. it is important to note; there is no mention of R2's toe until 9/17/26 in the nursing progress notes. On 9/17/25 R2's Nurse Progress note written by an LPN (Licensed Practical Nurse) indicated, on wound round writer looked at right lower leg/foot from the medial aspect of mid calf and down to toes across top of foot it is very moist and loose skin from blisters that had popped. top of foot down by toes has some whitish very moist area where there was a blister that had popped. area was cleansed and new oil emulsion, abd (abdominal pad) and kerlix was applied. resident stated that it was a little tender. redness noted around all and up leg d/t (due to) cellulitis. R2 was hospitalized from [DATE]-[DATE]. On 4/15/26 at 11:36 AM, Director of Nursing B (DON) indicated all wounds should be documented in the initial skin assessments. DON B stated, Yes, definitely, all wounds should be on the skin assessments so proper measurements and treatments are provided. DON B indicated weekly measurements should also be documented. On 4/15/26 around 4:00 PM, Nursing Home Administrator A (NHA) indicated skin assessments should (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	include all wounds and measurements. NHA A indicated understanding of the above concern. Example 3: The facility's Notification of Changes policy, dated 1/25, states, in part: The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notified, consistent with his or her authority, the resident's representative when there is a change requiring notification.Circumstances requiring notification include: .2. Significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental, or psychosocial status. This may include: .b. Clinical complications. R4 admitted to the facility on [DATE] and has diagnoses that include acute respiratory failure with hypoxia (a condition where the lungs cannot transfer enough oxygen to the blood); muscle weakness; pressure ulcer of sacral region; atherosclerotic heart disease (a condition where plaque builds up in the heart's arteries, restricting blood flow and oxygen) R4's Progress Notes include: On 4/11/26 at 8:12 PM .resident ate in room seems a bit off/depressed or sad. Stated neck and shoulders hurt when asked what was wrong. On 4/11/26 at 10:15 PM Resident seems different ate in room.R4 stated, I'm not sure maybe just a combination of things. On 4/12/26 at 11:00 AM Resident tearful and worried about what is going on with her.Resident reported that she had one episode of gagging and showed writer basin. No vomit noted. Clear sputum was noted in basin. Resident took her medication one by one. No swallowing issues or gagging noted. On 4/12/26 at 2:53 PM Resident stating she did not feel well, started spitting in tooth basin after a few minutes had a medium emesis. Will continue to monitor. On 4/12/26 at 9:35 PM .Resident was spitting then gagging then had medium emesis. Was crying at times had another episode before bedtime. Refused HS (bedtime) medication and wanted a Norco (pain medication) to rest. Stated she had not slept well in 3 nights. On 4/13/26 at 3:29 PM Resident was being assisted to the bathroom by writer, using gait belt and walker, resident leaned against her recliner that was in a raised position due to resident needing to use the bathroom, resident stated her leg got weak and she sat on recliner but was sliding out, writer used gait belt and lowered resident to floor. On 4/13/26 at 4:27 PM Writer met with resident and discussed her recent change of condition. Writer inquired about the resident going to the hospital for further evaluation. R4's Weights and Vitals Summary for 4/1/26 through 4/30/26 show assessment of Blood Pressure, Oxygen Saturation, Pulse, Respiration, and Temperature on 4/6/26 and 4/13/26. Important to note there are no vital signs documented for 4/11/26 or 4/12/26. On 4/14/26 at 9:50 AM, Surveyor interviewed RN E (Registered Nurse) and asked about the procedure (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	when a resident complains of not feeling well and/or is having emesis. RN E stated perform assessment with vital signs and bowel sounds. Document the vital signs and assessment in the progress notes; there is an additional section of the chart for vital signs as well as assessments. Tell the whole story, including who was updated. On 4/14/26 at 1:28 PM, Surveyor interviewed DON B (Director of Nursing) and asked about procedure when a resident complains of not feeling well and/or is having emesis. DON B stated assess vital signs, bowel sounds, pain, diet, medications. Keep the resident in their room until we know what is going on. Update the NP (Nurse Practitioner). Surveyor asked if there was an assessment or update to NP with R4's episodes of emesis on 4/12/26. DON B stated there should have been, yes. DON B reviewed R4's chart and stated there was no documentation of assessment or provider update. DON B stated the resident was hospitalized with urinary tract infection.

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F 0686 Level of Harm - 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 residents admitted without a pressure injury (PI) did not develop pressure injuries and did not ensure residents are provided cares and services consistent with professional standards of practice to prevent the development or worsening of PIs for 1 of 2 residents (R5) reviewed for pressure injuries.R5 was admitted to the facility with a cervical collar. The facility failed to complete skin assessments and R5 developed an unstageable pressure injury from his cervical collar. RN H (Registered Nurse) was observed not follow physician orders during treatment observation. Evidenced by: The American Medical Directors Association (AMDA) clinical practice guideline entitled, 'Pressure Ulcers and Other Wounds,' dated 2017, states in part: .A pressure ulcer (Injury) is localized damage to the skin or underlying soft tissue, usually over a bony prominence or related to a medical or other device. The ulcer may present as intact skin or as an open ulcer and may be painful. The ulcer occurs as a result of intense or prolonged pressure or pressure in combination with shear .Recognition: Early recognition of pressure ulcers and of any risk associated with the development of pressure ulcers and other wounds is critical to their successful prevention and management .Assessment: The purpose of the assessment is to collect enough information to evaluate the patient's general condition, characterize a pressure ulcer; and identify related causes and complications. The National Pressure Injury Advisory Panel (NPIAP) at www.NPIAP.com defines PIs in the following categories:Category/Stage III: Full thickness skin loss - Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscles are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. The depth of a Category/Stage III pressure ulcer varies by anatomical location.Unstageable/Unclassified: Full thickness skin or tissue loss - depth unknown. Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar are removed to expose the base of the wound, the true depth cannot be determined; but it will be either a Category/Stage III or IV.The facility's policy titled Pressure Injury Prevention and Management dated 2/2025 states in part .Definitions: Pressure Ulcer/Injury refers to localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. Avoidable means that the resident developed a pressure ulcer/injury and that the facility did not do one or more of the following: evaluate the resident's clinical condition and risk factors, define and implement interventions that are consistent with the resident needs, goals, and professional standards of practice; monitored and evaluated the impact of the interventions; and revised the approaches as appropriate.c. Wound assessments will be documented in the medical record. Findings should include type of wound, wound measurements (measured upon discovery, and at least weekly thereafter), other wound characteristics (color, exudate, pain, tissue type in wound bed), and treatment and interventions implemented.R5 was admitted to the facility on [DATE] with diagnoses that include posterior displaced type 2 Dens fracture (fracture is a break that occurs through a specific part of C2, the second bone in the neck), type 2 diabetes mellitus, and peripheral vascular disease (a common condition in which narrowed arteries reduce blood flow to the arms or legs).Of note: R5 was admitted without a pressure injury to his neck/back of head area.R5's most recent Minimum Data Set (MDS) dated [DATE] states that R5 has a Brief Interview of Mental Status (BIMS) of 15 out of 15, indicating that R5 is cognitively intact.R5's care plan dated 2/25/26 states in part: Focus: Skin Integrity: At risk /and/or potential for complications with impaired skin integrity including skin tears, bruising, and/or pressure r/t (related to) current medical/physical status. Has meds/dx (medications/diagnosis) that can/may affect skin integrity. Stage 3 to sacrum, non-pressure to R (right) heel, unstageable to back of head, venous wound to right calf tx (treatment) per wound MD (Medical Doctor) order (Revision on 4/14/2026) .Interventions/Tasks: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Assist/encourage pressure relief as needed/accepted. Follow community skin protocol. Observe skin with AM/PM (morning/evening) cares and with toileting for redness, rashes, open areas, pain, swelling and report them to team leader. Weekly skin check. Lotion to dry skin. Review skin concerns with MD.Of note, Surveyor reviewed R5's Physician orders and there is no order for staff to check the skin under or around R5's cervical collar. Additionally, there are no wound care orders entered to treat the PI on the back of R5's head.On 4/8/26, R5 had a visit with the Wound doctor. Documentation states in part .Focused Wound Exam (Site 5) Unstageable (due to necrosis) Head Full Thickness. Etiology: Pressure MDS 3.0 Stage: unstageable necrosis. Duration: > 7 days. Wound size (L (length) x W (width) x D (depth): 1.7 x 1.5 x not measurable cm (centimeters). Depth is unmeasurable due to presence of nonviable tissue and necrosis.Exudate: Moderate sero-sanguinous (thin, watery fluid that contains a small amount of blood mixed with serum). Thick adherent devitalized necrotic tissue: 80%. Granulation tissue: 20% .Additional Wound detail: Pressure wound from Rigid Cervical Collar at left/ middle occipital area. Dressing and treatment plan: Primary dressing: Alginate calcium apply once daily and as needed.Secondary dressing: Foam silicone border apply once daily and as needed.Peri wound treatment: skin prep apply once daily and as needed.On 4/14/26 at 9:56 AM, Surveyor observed R5's wound care with RN H (Registered Nurse) and LPN I (Licensed Practical Nurse). Surveyor observed RN H cleanse the wound to the back of R5's head, apply mepilex, and apply an ABD pad for comfort.It is important to note that RN H did not apply skin prep to the peri wound, nor is there an order for an ABD pad for comfort.Surveyor requested documentation of skin checks under R5's cervical collar, no documentation was provided.On 4/14/26 at 2:10 PM, Surveyor interviewed RN H. Surveyor asked RN H how often staff are completing skin checks under R5's cervical collar, RN H stated that they were doing them daily, Surveyor asked RN H if they documented the skin checks, RN H stated no. Surveyor asked RN H where they are documenting weekly skin checks, RN H stated that there is a weekly wound check/ weekly skin check under the assessments. Surveyor asked RN H if they are completing the assessments weekly, RN H stated no, but they will be from now on.On 4/14/26 at 2:21 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B if the facility has a wound nurse, DON B stated it was LPN I. Surveyor asked if LPN I is wound care certified, DON B stated no. Surveyor asked DON B how often staff should be completing weekly skin checks, DON B stated they should be completed on bath day. Surveyor asked if they should be documented, DON B stated yes. Surveyor asked DON B how often they would expect staff to be checking under a device for skin breakdown, DON B stated at least every shift. Surveyor asked DON B if checking under R5's cervical collar is in the physician's orders, DON B reviewed R5's orders and DON B indicated there was no order found. Surveyor asked DON B if they would expect nursing staff to check the skin under R5's cervical collar, DON B stated yes.On 4/15/26 at 1:35 PM, Surveyor interviewed LPN I. Surveyor asked LPN I when they were made aware of the pressure injury to the back of R5's head, LPN I indicated that LPN I and the wound doctor found the PI during wound rounds on 4/8/26. Surveyor asked LPN I if there was any documentation on the wound prior to 4/8/26, LPN I stated no. Surveyor asked LPN I if the nurses enter the admission orders into the computer, LPN I stated that DON B puts the orders in. Surveyor asked if R5 should have had an order entered to check the skin under their cervical collar, LPN I stated if the resident had orders not to remove the cervical collar, they would not expect staff to check the skin. Surveyor asked LPN I if R5 had an order to not remove the cervical collar, LPN I stated that they would have to look and would get back to Surveyor.It is important to note that Surveyor was not provided with any documentation instructing staff not to remove R5's cervical collar or to not check the skin under the medical device.On 4/15/26 at 3:33 PM, Surveyor interviewed MD J (Medical Doctor). Surveyor asked MD J if they would expect staff to be checking the skin under R5's cervical collar, MD J stated yes.R5 developed a medical device related pressure injury that was found to be an unstageable pressure injury due to nursing staff not checking R5's skin under his cervical collar daily.

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	525531	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Christian Home LLC	452 Fox Lake Road Waupun, WI 53963

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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 - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on 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 and to help prevent the development and transmission of communicable diseases and infection. This has the potential to affect all 34 residents who reside at the facility.The facility had tests that were positive for Legionella. The facility did not have water heater temperatures adequate to kill Legionella, did not provide interventions for R22's room to mitigate risk of exposure for R22, and did not do additional testing to ensure effectiveness of control measures taken in the building.Evidenced by:Per the CDC (Center for Disease Control and Prevention) page entitled Controlling legionella in potable water systems, indicates the following: Operation, maintenance, and control limits . Guidance . Monitor temperature, disinfectant residuals, and pH frequently based on performance of WMP or Legionella performance indicators for control. Adjust measurement frequency according to the stability of performance indicator values. For example, increase the measurement frequency if there's a high degree of measurement variability. Hot water: Store hot water at temperatures above 140 F (60 C). Ensure hot water in circulation does not fall below 120 F (49 C). Recirculate hot water continuously, if possible.Cold water: Store and circulate cold water at temperatures below the favorable range for Legionella (77-113 F, 25-45 C). Legionella may grow at temperatures as low as 68 F (20 C).The facility's Infection Prevention and Control Program policy, dated 5/25, states, in part: This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines.17. Water Management: a. A water management program has been established as part of the overall infection prevention and control program. b. Control measures and testing protocols are in place to address potential hazards associated with the facility's water systems. c. The Maintenance Director serves as the leader of the water management program.The facility's, (Company Name) Water Management Plan, undated, states, in part: .Control Measure Conduct validation testing in domestic water systems and other drinking water.Monitoring Test for Legionella at least four times yearly initially and then more frequently if indicated by test results.Frequency of Control Measure Task every 90 days .Corrective Action Respond to any Legionella-positive sample (per the diagram in Training Note 4.101) If positivity or concentrations exceed the team's limits, initiate remediation within 2 days of receiving the test results, taking a step-by-step approach. 4.101 Responding to Legionella Environmental Test Results.1. Communicate the results and take immediate measures necessary to reduce risk or comply with laws.Take required and appropriate measures to comply with laws and reduce health risk based on the test results, occupant risk, and cases of disease. Measures may include but not be limited to:*Following regulations as well as specific orders and given by health officials or other authorities having jurisdiction (AHJ)*Reporting the test results to AHJs, if required*Following the Responding to Disease section of your WMP (Water Management Plan)*Getting help from qualified consultants as appropriate*Implementing domestic water restrictions or installing faucet and shower filters rated for < (less than) 0.2 micron and validated to block Legionella*Emergency disinfection of cooling towers*Emergency disinfection of domestic water (plumbing) systems .2. Review the sampling plan for adequacy, especially if Legionella was not found. In its Legionella Control Toolkit, the CDC (Center for Disease Control) warns that any of the following indicates poor control of potable water (drinking water): *^ (greater than or equal to) 1 CFU/mL (Colony-Forming Units per milliliter-the concentration of living bacteria in a liquid sample)*10-fold concentration increase from one sampling round to the next*two or more Legionella-positive locations within a system (e.g. faucets in a potable water system)*Legionella in a location that serves multiple areas On 4/14/26 at 1:04 PM, Surveyor interviewed DON/IP B (Director of Nursing/Infection Preventionist) and MT C (Maintenance (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Technician) about water management. MT C stated about a year ago we looked at our water treatment system and felt that it wasn't needed. We contracted with a water management company and they suggested we get a baseline. 3 months after removing the water treatment system we tested and got some light positives.The facility's Legionella Summary Sheet, report date 9/22/25, indicates:* Date of Sampling: 9/10/25*Location [NAME] (Point of Entry) Cold Water Total Legionella (cfu/ml) ND (none detected)*Location Break Room Sink Total Legionella (cfu/ml) 14*Location [500 wing room number] Shower Total Legionella (cfu/ml) 23*Location Ice Machine 500 wing Total Legionella (cfu/ml) ND*Location [R22's room] Sink Total Legionella (cfu/ml) 26*Location Wing 400 Shower Room Total Legionella (cfu/ml) 20*Location [300 wing room number] Shower Total Legionella (cfu/ml) 15On 4/14/26, during continued interview with DON/IP B and MT C, MT C stated, we decided we needed to increase our flushing, then we tested again 2 weeks later.The facility's Legionella Summary Sheet, report date 10/8/25, indicates:*Date of Sampling: 9/30/25**Location Break Room Sink Total Legionella (cfu/ml) 3*Location [500 wing room number] Shower Total Legionella (cfu/ml) 3*Location [R22's room number] Sink Total Legionella (cfu/ml) 5*Location Wing 400 Shower Room Total Legionella (cfu/ml) ND*Location [300 wing room number] Shower Total Legionella (cfu/ml) 5On 4/14/26, during continued interview with DON/IP B and MT C, Surveyor asked what happened after the second round of testing. MT C stated we decided to go back to a chlorinated system, like we had, but now we will do a chlorine injection. We got bids on setting up a plan, and we started the chlorine injection last Thursday, 4/9/26, as there were issues with getting supplies from out of the country. MT C stated that the facility has continued the increased flushing; upped from 2 minutes to 5 minutes weekly. DON/IP B stated the facility has been monitoring residents for any signs of respiratory illness, staff were educated on what to look for and providers and the medical director were informed so that they'd be aware of a potential need to test residents. DON/IP B stated there have been no resident concerns. Surveyor asked if water temperatures are monitored. MT C stated yes, temperatures are monitored weekly at the water heater. Facility was at 111 degrees Fahrenheit (F) for scalding purposes; now set at 116 degrees F and resident rooms range from 111-114. Surveyor asked what temperature is needed to kill Legionella. MT C stated 117 or 123, don't recall for sure, but we can't keep our water heater temperature that high as we don't have anti-scald protection.On 4/14/26 at 4:10 PM, Surveyor interviewed R22 who stated that he/she washes up at the bathroom sink; (washing face and brushes teeth.)On 4/15/26 at 10:06 AM, Surveyor interviewed DON/IP B and MT C and asked about the water management plan's instructions following a positive test. DON/IP B, MT C and Surveyor reviewed the 4.101 notes. Surveyor asked if any of the interventions were implemented. MT C stated no, because we felt the numbers were low. Surveyor asked what a safe range for Legionella is, MT C stated he was unsure, but the consultant just advised on additional flushing. MT C stated, ultimately it was our decision how to proceed, the chlorination just took longer than we thought it would. Surveyor asked if there were any further interventions for R22's bathroom sink, water brought from another area / filter installed. MT C stated no, just additional flushing. DON/IP B stated residents don't generally drink from the sink in their room, water is distributed to them for drinking. Surveyor asked if water is consumed from the sink when brushing their teeth. DON/IP B stated yes. Surveyor asked if there is a potential for aspiration (inhaling fluid into lungs) when brushing their teeth. DON/IP B stated yes, of course. Yes, there is the potential for exposure to Legionella.On 4/15/26 at 2:20 PM, Surveyor reviewed concerns with NHA A (Nursing Home Administrator); positive tests with no further testing to determine if their water management plan has been effective, R22's continued possible exposure in their room, and water heater temperatures below 140 degrees which is not sufficient to kill Legionella. NHA A stated, I understand.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure that a resident who is unable to carry out activities of daily living (ADLs) receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 1 of 12 residents (R3) reviewed for grooming.R3 verbalized wish to be clean shaven and was observed with facial hair for three consecutive days.Evidenced by:The facility's Grooming a Resident's Facial Hair policy, dated 2/26, states, in part: It is the practice of this facility to assist residents with grooming facial hair to help maintain proper hygiene as per current standards of practice. Important to note: the policy does not indicate how often shaving is to occur.On 4/13/26 at 10:25 AM, Surveyor interviewed R3 during initial screening. Surveyor observed facial hair over R3's cheeks, chin, and neck and asked if resident liked facial hair or a clean shave. R3 stated he prefers to be clean shaven, but that doesn't always happen. R3 admitted to the facility on [DATE] and has diagnoses that include Parkinson's Disease (a progressive disorder with symptoms including tremors, stiffness, slow movement and balance issues); weakness; lack of coordination; mild cognitive impairmentR3's Minimum Data Set (MDS), dated [DATE], indicates a Brief Interview of Mental Status (BIMS) score of 13, indicating the resident is cognitively intact.R3's Care Plan Report includes:* Focus: with deficits with ADLs (activities of daily living) related to current medical/physical status. Has medications/diagnoses that can/may affect ADLs. Interventions/Tasks *Hygiene-1 minimal assist.*Focus: refuses cares. Goal-will have choices and able to make decisions through next review dateR3's Task Charting for Personal Hygiene: The ability to maintain personal hygiene, including combing hair, shaving. for 4/1/26 5:59 AM through 4/14/26 5:59 AM, shows documentation of a mix of dependent (helper does all), partial/moderate assist, and substantial/maximal assist. There is no documentation of resident refusal.On 4/14/26 at 9:40 AM, Surveyor observed R3 with facial hair and interviewed CNA F (Certified Nursing Assistant) about shaving. CNA F stated residents are shaved on bath days and if they request on other days. They can be shaven daily. Surveyor asked if R3 refuses cares/shaving. CNA F stated no, R3 asks about shaving and will do it himself with set up assist. CNA F stated, I'm not sure if it was offered today.On 4/15/26 at 8:15 AM, Surveyor observed R3 with facial hair and interviewed LPN G (Licensed Practical Nurse) about shaving. LPN G stated residents are usually shaved on bath day. LPN G stated R3's bath was Monday, 4/13/26. Surveyor asked if residents can be shaved more often than bath day if they wish to be clean shaven. LPN G stated yes. Surveyor asked if R3 was shaved. LPN G stated no.On 4/15/26 at 8:33 AM, Surveyor interviewed DON B (Director of Nursing) about shaving. DON B stated it should be offered daily.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure that it was free of medication error rates of 5% or greater. There were 2 errors out of 25 opportunities that affected 2 out of 8 residents (R14 & R1) included in the medication administration task, which resulted in an error rate of 8%. Surveyor observed RN E (Registered Nurse) prepare to crush R14's Pantoprazole DR (delayed release; a medication used to reduce stomach acid) to administer it to R14 before Surveyor stopped her. Surveyor observed RN D (Registered Nurse) did not prime R1's insulin pen before administration and did not keep the needle in the skin after administration to ensure proper dosing. This is evidenced by: The facility policy, Administering Medications, updated 10/2022, states in part: Policy Statement: Medications shall be administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation:. 2. Medications must be administered in accordance with the orders, including any required time frame. 5. The individual administering the medication must check the label against the Physician's order to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. Example 1: R14 was admitted to the facility on [DATE] with diagnoses that include gastro-esophageal reflux disease without esophagitis (GERD) (a digestive disorder with symptoms of chronic heartburn or acid reflux without visible damage to the esophagus) and a history of peptic ulcer disease (open sores in the stomach lining or top of the small intestine). R14's Physician Orders, dated 2/6/26, include, in part, the following medication: Pantoprazole Sodium Oral Tablet Delayed Release 20 mg – Give 1 tablet by mouth one time a day related to gastro-esophageal reflux disease without esophagitis. On 4/14/26 at 8:16 AM, Surveyors observed RN E prepare medications to administer to R14. RN E placed seven medication tablets into a plastic bag to crush for R14 to take with applesauce. One of the medications placed in the bag to crush was R14's Pantoprazole DR 20 mg tablet. It is important to note that delayed release medications are not to be crushed. According to MedlinePlus, pantoprazole DR is designed to pass through the stomach so it can be absorbed in the small intestine. Instructions for pantoprazole DR include: Swallow the tablets whole; do not split, chew, or crush them (https://medlineplus.gov/druginfo/meds/a601246.html). Crushing a delayed release medication hinders its therapeutic properties. On 4/14/26 at 8:19 AM, Surveyor stopped RN E right before she began crushing R14's medications in the plastic bag and asked if the pantoprazole should be crushed if it's a delayed release medication. RN E indicated she hadn't seen that the pantoprazole was delayed release. RN E pulled the medication card from the cart and looked at it with Surveyor. The card indicated that the pantoprazole was delayed release and instructions stated: Don't chew or crush. RN E removed the pantoprazole DR (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	from the plastic bag and said it shouldn't be crushed because it's delayed release. On 4/15/26 at 2:33 PM, Surveyor interviewed DON B (Director of Nursing). DON B confirmed that pantoprazole DR should not be crushed and indicated she would reach out to R14's doctor to get this prescription adjusted, as R14 has a hard time swallowing pills. Example 2: The facility's Insulin Pen policy, dated 2/26, states, in part: It is the policy of this facility to use insulin pens in order to improve the accuracy of insulin dosing. 6. Insulin pens will be primed prior to each use to avoid collection of air in the insulin reservoir.11. Procedure: .g. Attach pen needle.h. Prime the insulin pen: i. Dial 2 units by turning the dose selector clockwise. ii. With the needle pointing up, push the plunger, and watch to see that at least one drop of insulin appears on the tip of the needle. If not, repeat until at least one drop appears. i. Set the insulin dose. j. Injecting the insulin: .iii. Inject the needle straight at a 90-degree angle to the skin. iv. Fully depress the plunger until the dosing numbers count back to zero. v. While still pressing the plunger, keep the needle in the skin for up to 6-10 seconds and then remove the needle from the skin. Manufacturer's instructions for use of the HUMALOG-insulin lispro injection, solution, from the manufacturer's website (https://uspl.lilly.com/humalog/humalog.html#ug1) states, in part: .Priming your pen Prime before each injection. Priming your pen means removing the air from the Needle and Cartridge that may collect during normal use and ensures that the Pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin.Step 11. Insert the Needle into your skin. Push the Dose Knob all the way in. Continue to hold the Dose Knob in and slowly count to 5 before removing the Needle. On 4/14/26 at 12:04 PM, Surveyor observed RN D prepare Insulin Lispro (Humalog) (fast acting insulin) at the medication cart for R1. RN D applied a needle to the insulin pen and dialed the pen to 14 units. RN D gathered gloves and an alcohol prep pad and began to walk to R1's room. Surveyor asked RN D if the insulin pen was ready for administration. RN D stated yes. Surveyor asked if anything else needed to be done to the pen prior to administration. RN D stated I verified the dosing of 14 units, checked the dates and resident identifier on the label. Surveyor asked if there was anything additional in relation to applying a new insulin needle. RN D stated no, I cleansed with alcohol before the application. Surveyor asked if there is a way to verify that the pen/needle are functioning properly. RN D stated you can prime, but that is only done with a new pen. Surveyor and RN D reviewed manufacturer's guidelines regarding priming the pen and RN D primed the pen with 2 units, then dialed the pen to 14 units for administration. In the resident's room, RN D inserted the needle into R1's skin, administered the dose, then removed the needle from the skin. No hold time was noted. After leaving R1's room, Surveyor asked if there was anything that needs to be done after the injection / after the plunger is depressed and count on the pen returns to zero. RN D stated let it sit for a second or two. Surveyor asked if there is any count. RN D stated no. On 4/14/26 at 1:02 PM, Surveyor interviewed DON B (Director of Nursing) who stated that insulin pens need to be primed prior to setting dose for administration and the needle must remain in place for at least 10 seconds after administration.