| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 525533 | A. Building<br>B. Wing | 11/03/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Amethyst Health of Algoma | 1510 Fremont St<br>Algoma, WI 54201 |

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 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>(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 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review, the facility did not provide the necessary care and services to prevent pressure injuries from developing and/or promote healing for 1 Resident (R) (R2) of 2 sampled residents. On 8/5/25, R2 developed a facility-acquired stage 2 pressure injury on the gluteal cleft. R2 also had treatment orders for coccyx and sacral wounds. On 9/16/25, R2 was seen at the wound clinic. A provider note indicated R2 did not have an adequate wheelchair cushion when R2 arrived. The pressure injury was classified as a stage 4 and was infected. The facility did not ensure weekly wound assessments were completed timely or accurately for each of R2's wounds. The gluteal cleft pressure injury was not added to R2's care plan until 9/26/25. R2 was prescribed 2 courses of oral antibiotics, required a wound vac and a catheter, and was to start intravenous (IV) antibiotics for osteomyelitis (a bone infection that causes inflammation and destruction of bone tissue). In addition, R2's specialty bed was not on the correct weight setting and R2's wound vac was not changed as ordered. The facility's failure to ensure a resident received the appropriate care and treatment for a stage 2 facility-acquired pressure injury that progressed to a stage 4 infected pressure injury led to a finding of immediate jeopardy that began on 9/16/25. Nursing Home Administrator (NHA)-A was notified of the immediate jeopardy on 10/29/25 at 4:30 PM. The immediate jeopardy was removed on 10/29/25, however, the deficient practice continues at a scope/severity level D (potential for more than minimal harm/isolated) as the facility continues to implement its action plan. Findings include:The facility's Pressure Injuries and Non-Pressure Injuries policy, revised 7/2025, indicates: For those residents admitted with, or who subsequently develop a pressure injury or impaired skin integrity, they will receive care, treatment, and services that seek to promote healing, prevent infection, and prevent further development of pressure injuries/impaired skin integrity. The staging of pressure injuries is consistent with the recommendations of the National Pressure Injury Advisory Panel (NPIAP) and the Resident Assessment Instrument (RAI) manual.If pressure injury: Initiate the Pressure Injury Weekly Tracker User-Defined Assessment (UDA) - one per wound. If non-pressure injury: initiate the Non-Pressure Injury Tracker UDA - one per wound. Complete the Braden Scale to assess risk of developing a pressure injury. A Braden assessment tool will be completed.iii. Upon a significant change of condition.v. As needed.4. As needed or upon a significant change of condition: a. Complete a Braden Scale and update the plan of care as needed if changing/new risk factors. B. Review and update plan of care (if indicated) related to skin risk (actual/potential) for alteration in skin integrity. Mobility: As mobility scores decrease, concern about the adequacy of the support surface should increase - evaluate the need for specialty wheelchair cushion and specialty mattress.On 10/28/25, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] and had diagnoses including cerebral palsy, pressure ulcer of the sacral region stage 4, and osteomyelitis of vertebra sacral and sacrococcygeal region. A Significant Change of Condition Minimum Data Set (MDS) assessment, dated 9/23/25, indicated R2's cognition was not assessed. An MDS assessment, dated 7/24/25, had a Brief Interview for Mental Status (BIMS) score of 1 out of 15 which indicated R2 had severe cognitive impairment. R2 had a Corporate Guardian ((CG)-C) for healthcare decisions.R2's most recent Braden Scale assessment was completed 7/20/25 and indicated R2 was at high risk for the development of pressure injuries. Of note: The facility's policy indicates a new Braden Scale assessment should be completed with a Significant Change of Condition MDS which was not done on 9/23/25.A care plan (initiated 11/21/22 and last revised 10/2/25) indicated R2 had the potential for impaired skin integrity and/or pressure ulcer development related to impaired mobility, impaired cognition, bowel incontinence, and history of moisture-associated skin damage (MASD) to the gluteal cleft. The care plan contained interventions (dated 5/14/25) to encourage and assist R2 with turning/repositioning every 2 hours or more often as needed or requested; and Encourage and assist R2 to lie on R2's side after lunch.A care plan (initiated 9/26/25 and last revised 9/28/25) indicated R2 had a stage 4 pressure injury on the sacral region that was debrided at the wound clinic on 9/16/25 and 9/26/25. A wound vac was initiated on 9/26/25. The care plan contained interventions (dated 9/28/25) to complete treatments as ordered and monitor for effectiveness and adverse side effects; Implement pressure reducing devices (i.e., ROHO cushion in chair, air mattress, offloading heels); Monitor/document location, size, and treatment of skin injury. Report abnormalities, failure to heal, signs/symptoms of infection, maceration to MD; and Weekly wound documentation to include measurement of area of skin breakdown width, length, depth, type of tissue and |