STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525542	A. Building B. Wing	10/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Ridge Care Center	1400 8th Ave Union Grove, WI 53182

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 Level of Harm - Immediate jeopardy to resident health or safety 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 with a pressure injury or at risk for pressure injuries received necessary treatment and services, consistent with professional standards of practice, to prevent the development of pressure injuries and to promote healing for 3 of 3 residents (R1, R2, and R3) reviewed for pressure injuries. R1 admitted to the facility without any pressure injuries and was assessed as being at risk for pressure injuries. R1 developed a blister on the left buttock 10 days after admission that was not assessed by a Registered Nurse and the facility failed to revise R1's skin impairment care plan or pressure injury care plan after the area declined. Aggressive interventions including repositioning were not implemented even after R1 refused an air mattress. The wound continued to decline, eventually becoming infected, requiring antibiotics, and requiring surgical debridement. After debridement, the pressure injury was staged at a 4. The facility's failure to provide care to prevent the development of pressure injuries (PIs), failure to complete an RN assessment upon discovery of the PI, implement aggressive interventions, revise the plan of care and promote the healing of pressure injuries created a finding of Immediate Jeopardy (IJ) that began on 8/25/25. Surveyor notified Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B, Executive Director (ED)-C, and Assistant Administrator (AA)-O of the immediate jeopardy on 10/21/25 at 12:12 p.m. The immediate jeopardy was removed on 10/21/25, however, the deficient practice continues at a scope and severity of D (potential for harm/isolated) as the facility implements its action plan and due to the following examples: *R2 was observed not being repositioned on 10/16/25 and 10/20/25. On 10/20/25, R2's family member informed Surveyor they visit during the evening shift from approximately 1:00 p.m. to 9:00 p.m. and do not see R2 being repositioned. *R3 was readmitted to the facility on [DATE]. There was not a comprehensive assessment for R3's pressure injury until 9/29/25. On 10/20/25, R3 was observed without heels being offloaded and was not repositioned according to R3's plan of care. Findings include: (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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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's policy titled, Wound Management and reviewed 9/2025 under Policy Guidelines documents: (Name of facility) is committed to providing a comprehensive wound management program to promote the resident's highest level of functioning and well-being and to minimize the development of in-house acquired pressure injuries, unless the individual's clinical condition demonstrates they are unavoidable. Any resident with a wound receives treatment and services consistent with the resident's goals of treatment. Typically, the goal is one of promoting healing, prevent development of additional pressure injuries, and preventing the infection unless a resident's preferences and medical condition necessitate palliative care as the primary focus. A commitment to the Wound Management Program is demonstrated by implementation of processes founded on accepted standards of practice, research-driven clinical guidelines, and interdisciplinary involvement. Under section B. admission Wound Assessment and Management documents 2. Wounds are assessed within 8 hours of admission. A. Comprehensive assessment of any wound. This may include: Location of wound. Length, width, and depth measurements recorded in centimeters. Direction and length of tunneling and undermining. Appearance of the wound base. Type and percentage of tissue in wound. Drainage amount and characteristics including color, consistency, and odor. Appearance of wound edges. Description of the peri-wound condition or evaluation of the skin adjacent to the wound. Presence or absence of new epithelium at wound rim. Under section F Documentation and Care Planning 2. The wound management program documentation requirements include: a. Each hall's nurse manager and the Wound Care Nurse will assist in updating the care plan as needed. B. The care plan will be reviewed at the resident's quarterly care plan meeting. c. All care planning will follow the facilities care plan policy (see the care plan policy for a detailed description of care planning at name [name of facility]). 3. Resident risk factors and interventions are documented including but not limited to: a. Impaired mobility. b. Need for pressure relief such as support surfaces, repositioning, pressure relieving devices. c. Nutritional status. d. Incontinence. e. Skin condition. f. Complications such as infection and pain. g. General treatment regimen (delineating specific treatment is not necessary). 1.) R1 admitted to the facility on [DATE] with diagnoses that include right hip fracture, atrial fibrillation (irregular and rapid heart rate), chronic kidney disease (kidneys are damaged and cannot filter blood and waste effectively), morbid obesity, lymphedema (tissue swelling often in an arm or leg), congestive heart failure (heart doesn't pump enough blood to meet the body's needs), diabetes mellitus (high blood sugar), and hypertension (high blood pressure). R1's skin/wound note dated 5/20/25 written by Licensed Practical Nurse/Wound Nurse Manager (LPN/WNM)-G includes R1's right shin, right knee, left breast, right breast, right shoulder, left hand, left forearm, left inner elbow, right forearm, back, right ankle, left leg, left shin, right hand, and right and left heels. There is no documentation regarding R1's buttocks and no documentation of any open areas/pressure injuries. R1's Braden assessment dated [DATE] has a score of 17, which indicates at risk for pressure injury (PI) development. R1's impairment to skin integrity care plan initiated 5/22/25 and revised 7/31/25 documents the following interventions: *Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short. Initiated 5/22/25. *Encourage good nutrition and hydration in order to promote healthier skin. Initiated 5/22/25. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	*Follow facility protocols for treatment of injury. Initiated 5/22/25. *Use a draw sheet or lifting sheet to move resident. Initiated 5/22/25. *Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. Initiated 5/22/25. *Use alcohol prep pad to help remove therapy tape. Initiated 8/9/25 and resolved 10/1/25. R1's care plan indicates resident has stage 4 pressure injury to the left buttocks initiated 5/22/25 and revised 6/23/25 and documents the following interventions: The resident has an unstageable pressure injury to left buttock r/t (related to) limited mobility initiated 5/22/25 & revised 6/23/25 was revised to The resident has stage 4 pressure injury to left buttock r/t limited mobility initiated 5/22/25 & revised 9/8/25 documents the following interventions: *Follow facility policies/protocols for the prevention/treatment of skin breakdown. Initiated 5/22/25. *Monitor nutritional status. Serve diet as ordered, monitor intake and record. Initiated 5/22/25. *The resident requires the bed as flat as possible to reduce shear. The resident prefers to be repositioned with bariatric slide sheet. Initiated and revised 5/30/25. *Signed risk agreement for no air mattress. Initiated 6/26/25. *Ensure my Roho cushion is in my chair and properly inflated. Initiated 6/27/25. *Encourage resident to off load pressure to buttock, turn from side to side, don't stay up in chair too long. Initiated 7/28/25. *Staff to provide education on offloading and remind resident to turn from side to side when lying in bed. Initiated 8/18/25. *Ensure air mattress is inflated, functioning, and set on proper settings: Proactive proteckt aire 8000 set to 420 pounds, alternating every 10 minutes. Initiated 8/25/25 and revised 8/27/25. *Elevate heels while in bed with pillows. Initiated 10/16/25. *Ensure resident has w/c (wheelchair) cushion. Initiated 10/16/25. *Offer food choices to promote nutrition. Initiated 10/16/25. *RD (registered dietitian) consult, if recommendations are made update MD/NP/POA (medical doctor/nurse practitioner/power of attorney). *Use a draw sheet or lifting device to move resident. Initiated 10/16/25. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	*Use a minimum of two people assisting plus draw sheet in repositioning/boosting the resident up in bed. Initiated 10/16/25. R1's admission MDS (Minimum Data Set) with an assessment reference date of 5/24/25 has a BIMS (Brief Interview for Mental Status) score of 15 which indicates intact cognition. R1 is assessed as not having any behaviors including refusal of cares. R1 is assessed as requiring set up or clean up assistance for eating, and is dependent for toileting, roll left and right, chair/bed to chair transfer, and toilet transfer. R1 is frequently incontinent of urine and always incontinent of bowel. R1 is assessed for being at risk for pressure injuries and has no pressure injuries. R1's Braden assessment dated [DATE] has a score of 18 which indicates at risk for PI development. R1's pressure injury CAA (Care Area Assessment) dated 5/28/25 was triggered but not completed. Under analysis of findings for nature of problem/condition and care plan considerations, for describe impact of this problem/need on the resident and your rationale for care plan decisions are blank. R1's Braden assessment dated [DATE] has a score of 14 which indicates moderate risk for PI development. R1's nurses note dated 5/30/25, at 1624 (4:24 p.m.), written by LPN-P documents: new skin area on patients left buttock measuring 3 x (times) 3.5 blister caused by friction. Tx (treatment) entered into TAR (treatment administration record) HUCU (HIPPA compliant messaging app) message sent. Patient self-responsible and updated with plan of care. Care plan updated. Surveyor noted LPN-P did not specify details regarding the blister to indicate if it was fluid filled, what type of fluid (clear or blood), etc. Surveyor noted there is no Registered Nurse (RN) or Medical Doctor (MD) comprehensive assessment or evidence an RN reviewed LPN-P's assessment until 6/2/25 when the left buttock's skin impairment declined. R1's progress note dated 5/30/25 written by Dietitian-Q documents RD (registered dietitian) f/u (follow up): intakes continue to be good mostly 75-100% on supplement surgical areas improving weight is stable no recommendations. Wound MD-K's initial wound evaluation dated 6/2/25 under review of system for additional system documents: refused air bed despite education. Wound MD-K documents non-pressure wound of the left buttocks full thickness. Etiology is trauma/injury and further etiology detail is abrasion. Wound size is 4 x 3.5 x 0.1 cm (centimeters). Exudate is moderate serous. Slough is 20% and granulation tissue is 80%. Treatment is alginate calcium followed by gauze island with border dressing daily. The facility did not revise R1's skin impairment care plan or pressure injury care plan after R1's left buttock's skin impairment declined. The facility did not implement any aggressive interventions including repositioning and how often staff should reposition R1 to help heal or prevent the decline of R1's left buttocks skin impairment. Additionally, the facility did not assess to determine how friction to R1's skin was being prevented or if interventions were being appropriately implemented to prevent further decline in skin integrity. R1's Braden assessment dated [DATE] has a score of 17 which indicates R1 is at risk for PI development. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Wound MD-K's wound evaluation and management summary dated 6/9/25 under review of system for additional system documents: refused air bed despite education. Wound MD-K documents non-pressure wound of the left buttocks full thickness. Etiology is trauma/injury and further etiology detail is abrasion. Wound size is 4 x 3.5 x 0.1 cm. Exudate is moderate serous. Slough is 20% and granulation tissue is 80%. Wound progress is at goal and Wound MD-K continued the same treatment for R1. The facility still did not revise R1's skin impairment care plan or PI care plan. The facility did not implement any aggressive interventions or assess alternatives beyond an air mattress to include repositioning and how often staff should reposition R1 to help heal or prevent the decline of R1's left buttocks skin impairment. R1's continued risk for friction was not further assessed. Wound MD-K's wound evaluation and management summary dated 6/16/25 under review of system for additional system documents: refused air bed despite education. Wound MD-K documents non-pressure wound of the left buttocks full thickness. Etiology is trauma/injury and further etiology detail is abrasion. Wound size is 4 x 4 x 0.1 cm. Exudate is moderate serous. Slough is 50% and granulation tissue is 50%. Wound progress is not at goal due to increased exudate and Wound MD-K changed R1's treatment to leptospermum honey followed by gauze island border dressing daily. Surveyor noted although R1's left buttocks skin impairment continued to decline the facility still did not revise R1's skin impairment care plan or PI care plan. The facility did not implement any aggressive interventions. The facility was aware R1 declined an air mattress and did not have an intervention to reposition and how often staff should reposition R1 to help heal or prevent the decline of R1's left buttocks skin impairment. R1's continued risk for friction was not further assessed. R1's skin/wound note dated 6/16/25 at 1759 (5:59 p.m.), written by LPN/WNM-G includes documentation of: client now agreeable to air mattress, requested air mattress to be ordered. R1's nurses note dated 6/19/25, at 1810 (6:10 p.m.), written by LPN/WNM-G documents: Client is now refusing to have the air mattress I had one in the past they are just noisy, and I am afraid I won't be able to sleep. Resident would like to try a couple more weeks of no air mattress and will try to offload more often to help improve the wound. Risk and benefits explained to resident. Resident understands the wound could get worse but resident at this time continues to decline the air mattress. Surveyor noted there was no revision made to R1's skin integrity or PI plan of care to address R1 declining continued use of an air mattress and providing interventions to help with R1 offloading and preventing pressure and friction. Wound MD-K's wound evaluation and management summary dated 6/23/25 under review of system for additional system documents: refused air bed despite education. Wound MD-K documents unstageable (due to necrosis) of the left buttocks full thickness. Etiology is pressure (changed from non-pressure) and further etiology detail is abrasion. Wound size is 4 x 4 x 0.1 cm. Exudate is moderate serous. Necrotic tissue is 80% and granulation tissue is 20%. Wound progress is exacerbated due to noncompliant. Wound MD-K changed R1's treatment to Santyl followed by gauze island border dressing daily. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's nurses note dated 6/23/25, at 1558 (3:58 p.m.), written by LPN/WNM-G documents: Writer and wound care MD in to see resident. Resident wound has deteriorated. Risk and benefits of offloading were explained to resident. MD stated, I want to (sic) to know how serious this can be, if you don't want an air mattress and you don't offload you can get an infection, your wound will get worse could get to the bone and it could lead to death. Resident then stated, Well I wouldn't mind if I died. MD educated resident that death is preventable and offered help with the resident to be able to talk about her feelings. Resident stated, I would be better off dead because everything is so expensive. Writer and MD provided 1 to 1 with resident and before we left the room resident was no longer making statements. Writer updated IPC manager and SS (Social Service) on resident statement. On 6/25/25, R1 signed a Negotiated Risk Agreement which was dated 6/24/25. Under identify the cause for concern documents: Resident has a pressure wound to the buttocks that has shown signs of deterioration. Three weeks ago, an air mattress was recommended to assist with pressure redistribution and promote wound healing. At that time the resident declined the recommendation, stating the mattress was too noisy. The wound was stable initially, but during the following week, deterioration was noted. The air mattress was again suggested as part of the treatment plan. The resident initially agreed but later refused its use, again citing concerns about the noise level. Resident has been reeducated on the importance of pressure relief in wound healing, and the risks of further decline, including infection and delayed healing, have been explained. Alternative pressure relief strategies will continue, and the resident's decision has been documented. Under agreement documents: Resident to continue using standard facility mattress per preference. Pressure offloading strategies remain in place, including regular repositioning, use of pillows or wedges to reduce pressure on bony prominences, and close monitoring of skin integrity. Staff will continue to implement alternative pressure relief methods to support wound healing and prevent further breakdown. Although facility staff were aware R1 was refusing an air mattress on her bed the facility did not revise R1's impairment of skin integrity care plan or pressure injury care plan to include repositioning and how often R1 should be repositioned. R1's care plan was revised on 6/26/25 with signed risk agreement for no air mattress and ensure my Roho cushion is in my chair and properly inflated on 6/27/25. Wound MD-K's wound evaluation and management summary dated 6/30/25 under review of system for additional system documents: refused air bed despite education. Wound MD-K documents unstageable (due to necrosis) of the left buttocks full thickness. Etiology is pressure and further etiology detail is abrasion. Wound size is 4 x 3.5 x 0.1 cm. Exudate is moderate serous. Necrotic tissue is 80% and granulation tissue is 20%. Wound progress is improved evidenced by decreased surface area. Wound MD-K continued R1's same treatment. Wound MD-K's wound evaluation and management summary dated 7/7/25 under review of system for additional system documents: refused air bed despite education. Wound MD-K documents unstageable (due to necrosis) of the left buttocks full thickness. Etiology is pressure and further etiology detail is abrasion. Wound size is 3.5 x 3 x 0.1 cm. Exudate is moderate serous. Necrotic tissue is 80% and granulation tissue is 20%. Wound progress is improved evidenced by decreased surface area. Wound MD-K continued R1's same treatment. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Wound MD-K's wound evaluation and management summary dated 7/14/25 under review of system for additional system documents: refused air bed despite education. Wound MD-K documents unstageable (due to necrosis) of the left buttocks full thickness. Etiology is pressure and further etiology detail is abrasion. Wound size is 3.5 x 3 x 0.1 cm. Exudate is moderate serous. Necrotic tissue is 80% and granulation tissue is 20%. Wound progress is at goal. Wound MD-K continued R1's same treatment. Wound MD-K's wound evaluation and management summary dated 7/21/25 is the same as 7/14/25, however, under additional wound detail documents: educated on offloading, non-compliant. Wound MD-K's wound evaluation and management summary dated 7/28/25 is the same as above except for: Necrotic tissue is 100%. Wound progress is exacerbated due to noncompliant with offloading. Wound MD-K changed R1's treatment to Santyl, alginate calcium followed by gauze island with border dressing. Surveyor reviewed R1's medical record including progress notes and Certified Nursing Assistant (CNA) documentation under the task tab for roll left and right (bed mobility). There is no evidence in R1's medical record R1 refused to be repositioned. R1's impaired skin integrity care plan and pressure injury care plan do not address repositioning. There is not a refusal care plan nor are there any interventions addressing R1's refusal to reposition in any of R1's care plans. R1's nutrition note dated 7/29/25 written by Dietitian-Q documents: RD (Registered Dietitian) review r/t (related to) wound; resident with a pressure injury unstageable to her Lt (left) buttock which has shown a decline. Stable wt (weight). Diet is CCD (carbohydrate-controlled diet). Intakes 76-100%, with a few 51-75% over the last month. Glucerna 237 ml (milliliters) once daily after breakfast, 50-100% intakes. Est (estimated) needs: 2781 kcal/day (kilocalorie per day) Adj BW, 111-120gPro/day (grams protein per day) based on 1.2-1.3 gPro/kg Adj BW. Good glycemic control based on BGL (blood glucose level). Recommend increase Glucerna to 237 ml twice daily between meals. Also start Protein liquid 30ml once daily. Gradual wt (weight) loss acceptable to improve BMI. Wound MD-K's wound evaluation and management summary dated 8/4/25 under review of system for additional system documents: refused air bed despite education. Wound MD-K documents unstageable (due to necrosis) of the left buttocks full thickness. Etiology is pressure and further etiology detail is abrasion. Wound size is 3.5 x 2.5 x 0.1 cm. Exudate is moderate serous. Necrotic tissue is 100%. Wound progress is improved evidenced by decreased surface area. Wound MD-K continued R1's same treatment. Wound MD-K's wound evaluation and management summary dated 8/11/25 is the same as 8/4/25 with the exception of wound size. Wound size is 3 x 2 x 1 cm. Wound MD-K's wound evaluation and management summary dated 8/18/25 documents the same as 8/11/25 except for: Wound size is 3 x 3 x 2 cm. Necrotic tissue is 90% and 10% granulation. Wound progress is exacerbated due to noncompliant with offloading despite weekly education, refused air bed again. Wound MD-K changed R1's treatment to 1/2 strength Dakin's, alginate calcium followed by gauze island with border dressing. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Surveyor reviewed R1's medical record including progress notes and Certified Nursing Assistant (CNA) documentation under the task tab for roll left and right (bed mobility). There is no evidence in R1's medical record R1 refused to be repositioned. R1's impaired skin integrity care plan, pressure injury care plan, and CNA Kardex does not address repositioning. There is not a refusal care plan nor are there any interventions addressing R1's refusal to reposition in any of R1's care plans. R1's Braden assessment dated [DATE] has a score of 16 which indicates at risk for PI development. R1's skin/wound note dated 8/18/25 at 15:04 (3:04 p.m.), written by LPN/WNM-G documents: [Wound MD-K's name] and writer educated resident on risk and benefits of air mattress, offloading and importance of eating well. Resident continues to refuse air mattress. Risk agreement remains on file. Resident stated she will try to offload more and will focus on consuming protein. R1's quarterly MDS with an assessment reference date of 8/21/25 has a BIMS score of 15 which indicates intact cognition. R1 is assessed as not having any behaviors including refusal of care. R1 is assessed as being independent for eating, partial/moderate assistance for toileting, substantial/maximal assistance for roll left and right, and dependent for chair/bed to chair transfer, and toilet transfer. R1 is frequently incontinent of urine and always incontinent of bowel. R1 is at risk for pressure injury development and has one unstageable pressure injury. R1's nurses note dated 8/22/25 at 10:59 a.m., written by Licensed Practical Nurse/Unit Manager (LPN/UM)-M documents: Resident is her own person and re-signed risk agreement for refusing air mattress at quarterly care conference. Resident was educated on the risk vs benefits of refusing air mattress r/t (related to) wound healing. Wound MD-K's wound evaluation and management summary dated 8/25/25 under review of system for additional system documents: refused air bed despite education. Offloading with education while husband in room. Wound MD-K documents unstageable (due to necrosis) of the left buttocks full thickness. Etiology is pressure and further etiology detail is abrasion. Wound size is 3 x 3 x 5 cm. Exudate is moderate serous. Necrotic tissue is 100%. Wound progress is exacerbated due to noncompliant with offloading despite education. Infection assessment documents one or more sign(s) of clinical infection. Under expanded evaluation performed documents: The progress of this wound and the context surrounding the progress were considered in greater detail today. Patient requiring an increase in the level of care. Cellulitis: doxycycline 100mg (milligram) po (by mouth) bid (twice daily) x 14 days, probiotics 2 tabs daily x 30 days. Wound MD-K changed R1's treatment to 1/2 Dakin's followed by gauze island with border dressing two times daily. Surveyor reviewed R1's medical record including progress notes and Certified Nursing Assistant (CNA) documentation under the task tab for roll left and right (bed mobility). There is no evidence in R1's medical record R1 refused to be repositioned. R1's impaired skin integrity care plan, pressure injury care plan, and CNA Kardex does address repositioning. There is not a refusal care plan nor are there any interventions addressing R1 refusal to reposition in any of R1's care plans. Surveyor also noted despite the documentation of R1 refusing use of an air mattress, there is no indication an alternate support surface was discussed, assessed or offered beyond an air mattress or the facility standard mattress. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's skin/wound note dated 8/26/25 at 07:20 (7:20 a.m.) written by LPN/WNM-G documents: DX (diagnosis) of cellulitis on [wound company name] note, wound to left buttock is hot, red, increased drainage noted, foul odor. [Wound MD-K's name] ordered wound culture f/b (followed by) ATB (antibiotic) therapy to begin once wound culture was obtained. New orders for ATB placed, CP (care plan) created, TAR (Treatment Administration Record) updated. Client responsible and aware of new orders. Surveyor noted the date of Wound MD-K's note is 8/25/25. Wound MD-K's wound evaluation and management summary dated 9/1/25 under review of system for additional system documents: refused air bed despite education. Offloading with education while husband in room. Wound MD-K documents unstageable (due to necrosis) of the left buttocks full thickness. Etiology is pressure and further etiology detail is abrasion. Wound size is 3 x 3 x 5 cm. Undermining is 6 cm at 2 o'clock. Exudate is moderate serous. Necrotic tissue is 100%. Wound progress is exacerbated due to infection, noncompliant. Infection assessment documents: No sign(s) of infection. Surface culture of unstageable (due to necrosis) of the left buttock demonstrates enterococcus faecalis, MRSA (methicillin-resistant staphylococcus aureus) on 8/26/25. Wound MD-K continued with the same treatment. Under expanded evaluation performed documents: The progress of this wound and the context surrounding the progress were considered in greater detail today. Patient requiring an increase in the level of care. Spoke extensive [sic] with patient and husband on a nonhealing wound, history of noncompliance, and infected wound on oral antibiotics. Family agrees with sending to ER (emergency room) for further evaluation. R1 was hospitalized on [DATE] and returned to the facility on 9/5/25. R1's hospitalist Discharge summary dated [DATE] under discharge diagnoses documents principal problem: Wound of sacral region, initial encounter. admission condition is documented as poor. Discharge condition is documented as stable. Under hospital course for hospital summary documents past medical history of hip fracture with surgery in May 2025 after fall at [Name], diabetes mellitus, chronic kidney disease, obstructive sleep apnea on CPAP (continuous positive airway pressure), atrial fibrillation, morbid obesity, osteoporosis who was admitted for sacral wound infection and developing abscess. She has been mostly bed bound at the facility since her hip surgery. She was started on PO (by mouth) antibiotics in the outpatient setting; however, wound was worsening therefore she was brought here for evaluation. She was admitted and started on IV (intravenous) antibiotics. General surgery was consulted, and she underwent surgical debridement in the OR (operating room) on 9/2. Cultures are positive for staph aureus, likely MRSA (methicillin-resistant staphylococcus aureus). Infectious disease consulted and have recommended Zyvox (an antibiotic) for 7 additional days at discharge. Wound care consulted and she had a wound VAC (vacuum-assisted closure) placed in house which has since been removed with the recommendations being to continue daily wet to moist dressings. She will need to offload for the wound to heal. discharged to SNF (skilled nursing facility). R1 returned to the facility on 9/5/25 with a Stage 4 left buttock pressure injury. R1's skin only evaluation dated 9/5/25 created by LPN-R and revised by Director of Nursing (DON)-B, dated as still in progress, under skin note documents: back of left thigh wound Measurements: length 7cm Width: 3 1/2 cm no tunneling depth: 5 cm. Bruises noted on left arm: L (left) upper 1 inch long, forearm 1 inch long. Bruise on Right hand 2 inches long. Bruise on Right forearm 1 inch long. Under other education notes documents: Resident is aware of turning every 2 hours to stay of [sic] (off) wound site. Wedges in place. (continued on next page)

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	525542	A. Building B. Wing	10/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Ridge Care Center	1400 8th Ave Union Grove, WI 53182

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Surveyor noted LPN-R documented R1's left buttock as left thigh. This skin only evaluation is not a comprehensive assessment as there is no stage, no description of the wound bed with percentages of the wound bed tissue, no documentation regarding drainage, etc. R1's Braden assessment dated [DATE] has a score of 18 which indicates R1 is at risk for PI development. R1's physician order dated 9/5/25 documents: document on resident's noncompliance with turning and repositioning and if any education was provided. Wound MD-K's wound evaluation and management summary dated 9/8/25 under review of system for additional system documents: refused air bed despite education. Offloading with education while husband in room. Wound MD-K documents Stage 4 pressure wound of the left buttock full thickness. Etiology is pressure and further etiology detail is abrasion. Wound size is 7 x 4 x 5.5 cm, undermining is 1 cm at 2 o'clock, and exudate is moderate serious. Necrotic tissue is 40% and granulation is 60%. Wound progress is exacerbated due to recent return from hospital. Wound MD-K ordered a treatm

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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 - Few	Provide and implement an infection prevention and control program. (continued on next page)

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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 - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility did not maintain an infection prevention and control program designed to reduce the transmission of disease and infection for 1 (R3) of 3 residents.*During wound care, hand hygiene was not performed prior to placing a clean dressing on R3's stage 4 sacral pressure wound.Findings include:The facility policy titled Wound Management with effective date 10/2020 and reviewed date 9/2025 documents: . committed to providing a comprehensive wound management program to promote the resident's highest level of functioning and well-being and to minimize the development of in-house acquired pressure injuries, unless the individual's clinical condition demonstrates they are unavoidable. Any resident with a wound receives treatment and services consistent with the resident's goals and treatment. A commitment to the Wound Management Program is demonstrated by implementation of processes founded on accepted standards of practice, research-driven clinical guidelines, and interdisciplinary involvement. Wound care/dressings:-general infection control practices are maintained during wound care and dressing changes.The facility policy titled Wound Dressing Change with effective date 4/19/19 and reviewed date 9/2024 documents: The purpose of this procedure is to provide guidelines for the approved method of removing, cleaning, and applying wound dressings . Procedure: -gather all necessary supplies.-perform hand hygiene and put on personal protective equipment (PPE), if indicated.-place a waste receptacle or bag at a convenient location for use during the procedure.-put on clean, disposable gloves and loosen tape on old dressings.-carefully remove the soiled dressings.-place soiled dressings in the appropriate waste receptacle. -remove gloves and dispose of them in an appropriate waste receptacle.-perform hand hygiene.-open supplies needed to re-dress the wound.-put on gloves.-clean the wound.-pat the wound dry if ordered. Apply ointment or perform other treatments as ordered.-apply ordered dressing over the wound.-remove and discard gloves.The Centers for Disease Control guideline titled Clinical Safety: Hand Hygiene for Healthcare Workers dated 2/27/24, documents hand hygiene should be performed . immediately before touching a patient . before moving from work on a soiled body site to a clean body site on the same patient . after contact with blood, body fluids, or contaminated surfaces . immediately after glove removal. The guideline documents gloves should be changed and hands cleaned if gloves become soiled with blood or body fluids after a task . if moving from work on a soiled body site to a clean body site on the same patient.R3 admitted to the facility on [DATE] with diagnoses including pressure ulcer of sacral region (lower back), stage 4, osteomyelitis (infection of the bone), anxiety, Type 2 Diabetes Mellitus, depression, pressure ulcer of left lower back, stage 3, and pressure ulcer of right heel, unstageable. R3's Significant Change Minimum Data Set (MDS) dated [DATE] documents R3 has a pressure ulcer, is at risk of developing a pressure ulcer, and has one stage 4 pressure ulcer which was present upon admission. R3's physician order dated 9/29/25 for wound treatment to the sacrum documents: Clean wound with wound cleanser or normal saline, pat dry, apply calcium alginate to wound bed, followed by bordered island dressing . every day shift.On 10/16/25, at 10:57 AM, a Surveyor observed wound treatment performed by Registered Nurse (RN)-F for R3's stage 4 sacral pressure wound. A Surveyor observed RN-F wash hands and don PPE prior to beginning wound treatment. At 11:01 AM, A Surveyor observed RN-F remove R3's old dressing on R3's sacrum, remove gloves, wash hands, and don new gloves. At 11:10 AM, a Surveyor observed RN-F cleanse sacral wound with wound cleanser, dab the wound with gauze, remove the gauze, apply calcium alginate, then cover the wound with a border dressing. A Surveyor noted RN-F did not change gloves or perform hand hygiene prior to applying a new border dressing after coming in contact with the wound when applying wound cleanser and calcium alginate. On 10/20/25, at 3:00 PM, Surveyor shared concern with Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B, and Executive Director (ED)-C that proper hand hygiene was not observed during R3's wound treatment. No further information was provided. On 10/21/25, at 9:28 AM, Surveyor interviewed Licensed Practical Nurse Wound Nurse Manager-G who stated when performing wound treatments, staff would be expected to perform hand hygiene before starting treatment, anytime after coming in contact with dirty dressings, and when completing wound care. On 10/21/25, at 9:47 AM, NHA-A and DON-B stated education has been provided regarding proper hand hygiene during wound dressing changes. No additional information was provided.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility did not have documentation of completion of 12 hours of required in-service training for 5 of 5 Certified Nursing Assistants (CNAs) reviewed potentially affecting all 71 residents in the facility.CNA-W, CNA-X, CNA-Y, CNA-Z, and CNA-AA did not have documentation of completing the 12 hours of required in-service training.Findings include:The Facility assessment dated [DATE], last reviewed 8/6/2025, documents: Staff Training/Education and Competencies .-Required in-service training for nurse aides. In-service training must: Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year.CNA-W was hired on 7/18/2023 so the review of training was 7/18/2024-7/18/2025.CNA-X was hired on 12/26/2022 so the review of training was 12/26/23-12/26/2024.CNA-Y was hired on 5/22/2024 so the review of training was 5/22/2024-5/22/2025. CNA-Z was hired on 7/26/2023 so the review of training was 7/26/2024-7/26/2025.CNA-ZZ was hired on 2/6/2024 so the review of training was 2/6/2024-2/6/2025.On 10/28/2025 at 10:37 AM, Surveyor requested from Executive Director (ED)-C and Director of Nursing (DON)-B employee files for review of training and education for CNA-W, CNA-X, CNA-Y, CNA-Z, and CNA-AA. ED-C shared the request with Assistant Administrator (AA)-O. AA-O asked for clarification of what was requested. Surveyor shared with AA-O, ED-C, and DON-B that CNAs need to have documentation of receiving 12 hours of education annually per their hire date. DON-B stated DON-B would look for that information and provide what DON-B could locate.ED-C provided to Surveyor an undated document with employee names and number of hours of training. The document did not denote what type of education or when the education was provided. Surveyor shared with ED-C the need to see when the education was provided, what education was provided, and the length of the education to show CNA-W, CNA-X, CNA-Y, CNA-Z, and CNA-AA had the required 12 hours yearly of education based on their date of hire. Surveyor shared with ED-C the education was based on the month of hire and was a rolling year depending on that date; an example was given if an employee was hired on 2/1/2023 then the training hours and topics that would be reviewed would be from 2/1/2024 to 2/1/2025 since that would be the most recent year based on the hire date. ED-C acknowledged understanding of what was requested.DON-B provided to Surveyor multiple sign-in sheets attached to in-service trainings. DON-B provided written quizzes completed by CNA-W, CNA-X, CNA-Y, CNA-Z, and CNA-AA. Some of the quizzes were not dated and the CNA that completed a quiz did not consistently sign the in-service sign-in sheet. Surveyor asked DON-B if CNA-W, CNA-X, CNA-Y, CNA-Z, and CNA-AA had documentation of what trainings had been received and when. DON-B stated no, they did not keep individual records. Surveyor asked DON-B how DON-B knew if each employee had the training that was required annually. DON-B stated DON-B would have to look at each in-service sign-in sheet to see if the employee had attended.On 10/28/2025 at 3:30 PM, Surveyor shared with ED-C, DON-B and AA-O the concern CNA-W, CNA-X, CNA-Y, CNA-Z, and CNA-AA did not have the documentation of completing required training in the timeframe based on the hire date of the employee. DON-B agreed there was not a system in place to monitor the training completed or required for employees.On 10/29/2025 at 12:04 PM via email, ED-C provided a spreadsheet with staff education topics, dates provided, and hours per topic. The spreadsheet had an initial date of 10/9/2024 and a final date of 10/10/2025. The spreadsheet did not incorporate the rolling 12 months from the CNA dates of hire to show training was completed during the individual timeframes.