STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525556	A. Building B. Wing	01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookside Care Center	3506 Washington Rd Kenosha, WI 53144

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 - 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** 29015 Based on interviews, record review, and review of facility policy, the facility failed to ensure that one of three residents (Resident (R)1) reviewed for pressure ulcers out of a total sample of five did not develop a pressure ulcer, unless their clinical condition showed that it was unavoidable. R1, who entered the facility without any skin issues to his right heel, developed a facility-acquired deep tissue injury (DTI) pressure ulcer that deteriorated to an unstageable ulcer. There was no documentation the facility monitored R1's skin and implemented interventions as ordered by the physician and identified in the resident's plan of care. Findings include: Review of the facility's policy titled Prevention of Pressure Ulcers dated 01/06/23, revealed, . The care plan should address the potential for skin breakdown for residents who are at risk. At risk residents will have appropriate pressure-reducing devices on their wheelchair. The resident who is unable to change position on their own will be repositioned frequently according to their individual needs. Resident will be repositioned using appropriate lifting techniques or equipment (ex. Lift sheet) to prevent friction and shearing. Pillows or other devices will be used as needed to prevent pressure between the knees, ankles, etc. When in bed, the immobile resident will have their heels elevated off the bed so that they are 'floating.' Any sign of pressure ulcer formation will be identified, and treatment will be initiated in a timely manner to prevent further tissue damage . Review of R1's undated Face Sheet, located in the electronic medical record (EMR) under the Face Sheet tab, indicated the resident was admitted to the facility on [DATE] and discharged on [DATE]. Diagnoses included fracture of the left acetabulum (pelvic region); multiple fractures of ribs, wedge compression fractures of the first, second, and third vertebra; and benign prostatic hyperplasia (enlarged prostate). (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 Level of Harm - Actual harm Residents Affected - Few	Review of R1's admission Minimum Data Set (MDS), located in the EMR under the MDS tab, revealed R1 had a Brief Interview of Mental Status (BIMS) score of nine out of 15, which indicated the resident was moderately cognitively impaired. It was recorded that R1 required extensive assistance of two staff members for bed mobility, transfers, locomotion off/on unit, dressing, toilet use, and personal hygiene. It was recorded that R1 had a urinary catheter and was occasionally incontinent of bowels. It was recorded R1 was admitted with one unhealed stage II pressure ulcer to the sacrum and was assessed as being at risk for further pressure ulcer development. It was recorded that skin treatments/interventions included pressure reducing devices for the bed, pressure ulcer/injury care, surgical wound care, and applications of ointments/medications. Review of R1's Care Plan, initially dated 08/17/23 and located in the EMR under the Care Plan tab, revealed the resident had the potential for pressure ulcer development related to decreased mobility/generalized weakness following hospitalization due to pelvic fracture. The short term goal was, . will have intact skin free of redness, blisters, or discoloration . Approaches included, . check my skin during cares; complete a full body checks weekly and document, reduce pressure/friction between myself and my bed/chair, evaluate my skin under tubing or other devices that are in direct contact with my skin, reposition and assist me with bed/chair mobility frequently to prevent pressure to my skin, reposition and assist me with bed/chair mobility frequently to prevent pressure to my skin, provide incontinence care as needed to keep my skin clean and dry, and elevate my heels when I'm in bed. Monitor my nutrition and hydration status, follow facility protocols for prevention of skin breakdown. Review of R1's Admission Assessment, dated 08/17/23 at 2:00 PM and located in the EMR under the Progress Notes tab, indicated the resident had excoriation to the coccyx and a dark purple bruise to the right buttock, measuring 1.5 centimeters(cm) by 0.8 cm. Skin and Ulcer/Injury Treatments indicated applications of a non-surgical dressing and application of an ointment/medication. There was no documentation of any pressure ulcers to the resident's heels. Review of R1's Observation Detail List Report: Braden Scale, dated 08/17/23 at 6:41 PM and located in the EMR under Observation tab, revealed R1's Braden scale score was a 16, which indicated the resident was a mild risk for the development of pressure ulcers. Review of R1's EMR, dated 08/17/23 through 10/03/23, revealed no documented evidence that R1's heels were floated as per the care plan interventions, that skin checks were performed during care, or that the resident was repositioned frequently. Review of R1's Progress Note, dated 10/04/23 at 10:18 PM and located under the Progress Notes tab of the EMR, revealed . called to room re: blister 5 x 5.5 cm to right heel, skin prepped area and heel lift placed under legs to elevate heels. Updated Hospice re: new area and re: skin tear to left buttock as there were no orders for treatment. Treatment orders in place for border gauze to left buttock and skin prep to right heel. Hospice nurse will evaluate right heel in am . Review of R1's Care Plan, located under the Care Plan tab of the EMR and dated 10/04/23, revealed the resident's Care Plan was updated to include, . Pressure Ulcer/Injury I have a blister/DTI [deep tissue injury] to my right heel and need a heel riser to help protect it when in bed HEEL BOOT ON AT ALL TIMES . Interventions included, . apply treatment as ordered by MD. Chartable Task in POC [Point of Care]: unchecked [,] Care Needs Sign-off in POC: unchecked [,] Include on Profile: unchecked . (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of a hospice Nursing Visit Note, dated 10/05/23 at 1:45 PM, revealed, . new DTI to right heel. Writer took off shoe and assessed right heel. New orders obtained for treatment to include skin prep bid and off-loading boot on right foot at all times . new order for tubi grips [a tubular bandage that provides support for the treatment of soft tissue injuries] . Review of R1's Progress Note, dated 10/05/23 at 2:27 PM and located under the Progress Notes tab of the EMR, revealed, . Hospice in this afternoon to see resident. Verbal orders were given to keep heel boot on right foot at all times to help offload pressure to DTI [deep tissue injury], tubi-grips on in AM [morning], and off HS [bedtime] . Review of R1's Progress Note dated 10/09/23 at 10:34 AM and located under the Progress Notes tab of the EMR, revealed . Received order from MD [medical doctor] 1. Apply tubi grips on in a.m., off HS, 2. Keep off loading boot on at all times right foot DTI. 3. Skin prep right BID for DTI . Review of a hospice Nursing Visit Note, dated 10/09/23 at 9:00 AM, revealed, . Teaching provided during visit . instructed to make sure to be [sic] grips are cut to length of his legs and heel boot is too [sic] right heel at all times, and to not wear shoes . reported his right heel was hurting. Writer propped foot up on pillows to view heel. Skin to deep tissue injury head [sic] come off and blood was noted to heal [sic] . RNCM [RN Case Manager] called and made aware area was now open. New wound care orders obtained. Xeroform and calcium alginate applied and dry clean dressing . Writer then assisted [R1] with tubi grips to legs . Facility staff instructed to keep shoe off of right foot and to make sure to be [sic] grips are cut to length . RN was going to give PRN medication due to pain in right heel . Review of R1's Progress Note, dated 10/09/23 at 12:00 PM and located under the Progress Notes tab of the EMR, revealed, . right heel [dressing] will be changing . Right heal [sic] scab is off hospice nurse applied foam dressing to have boot on as much as possible . Will have order for xerofoam CA [calcium] alginate and bordered dressing to heal [sic] . Review of R1's Care Plan, located under the Care Plan tab of the EMR, revealed no documented evidence the resident's Care Plan was updated to include the deterioration of the resident's pressure ulcer from a DTI to an unstageable pressure ulcer or any new interventions were identified or implemented. Review of the Skilled Nursing Facility (SNF) Progress Note: Wound Care Assessment, dated 10/28/23 and located in the EMR under the Resident Documents tab, revealed interventions in place as, . pressure reduction devices, bed, cushion per facility protocol, nursing and wound care, nutritional support, and heel offloading boot in place at all times. Physical Examination: Unstageable pressure injury of right heel, full thickness wound measuring 5.5 cm x 6.0 cm x UTD. Scant serosanguineous drainage around the edges of the eschar . Status: improved . Assessment . Heel boot in place at all times except transfers . Review of R1's Point of Care (POC) documentation (documentation of CNA activities for the resident) for 08/17/23 through 10/30/23, located in the EMR under the POC tab, revealed no documentation R1 was repositioned frequently, that his heels were elevated, that skin checks were performed with care, or that the right heel boot was used as ordered. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 01/31/25 at 1:08 PM, Certified Nurse Aide (CNA)1 was asked if he remembered R1. CNA1 stated he did not recall the resident. CNA1 was asked what the process was for resident's pressure ulcers. CNA1 stated that the CNAs perform body checks on admission, and skin checks during care. During an interview on 01/31/25 at 1:47 PM, Registered Nurse (RN)1, RN1 was asked if he recalled identifying R1's heel ulcer. RN1 stated he did not recall the resident, but that he was part of the wound care team at that time. RN1 added, We (the facility staff) try to do everything we can to help residents to not develop pressure ulcers. During a telephone interview conducted with CNA2 on 01/31/25 at 1:58 PM, CNA2 was asked if he remembered providing care to R1. CNA2 stated he did not recall the resident, family, or any of the care he may have provided to the resident. An attempt to contact RN2 was made on 01/31/25 at 2:02 PM, and a message was left to return phone call. RN2 was the nurse who initially documented the resident had a deep tissue injury (DTI). During an interview with the Director of Nursing (DON) on 01/31/25 at 3:45 PM, and again at 4:45 PM, the DON was asked if there was any documented evidence that R1 was repositioned frequently, that skin checks were being completed with care, that the resident's heels were elevated, and that the tubi grips and heel boot were applied as ordered. No documentation was provided by the end of the survey.