

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525568	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2025
NAME OF PROVIDER OR SUPPLIER Sunny Ridge Operations LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3014 Erie Ave Sheboygan, WI 53081	
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)		
<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38793</p> <p>Based on observation, staff interview, and record review, the facility did not provide the appropriate care and services to prevent pressure injuries from developing and/or promote healing for 1 resident (R) (R1) of 5 sampled residents.</p> <p>On 12/19/24, R1 developed what was initially classified as an arterial wound on the left foot (hallux) by former Assistant Director of Nursing (ADON)-C, who is not wound care certified. Pressure relieving interventions for R1's feet were not implemented, and the wound was not formally assessed until 1/2/25. R1 was hospitalized from 1/11/25 to 1/13/25 for pneumonia and a urinary tract infection (UTI). On 1/13/25 at the hospital, R1's left foot wound was classified as an unstageable deep tissue injury. Pressure-relieving interventions (heel boots) for R1's feet were not implemented or added to R1's plan of care until 1/23/25. On 1/29/25, R1's wound was classified as a stage 4 pressure injury and the treatment order was changed. Staff did not transcribe the new treatment order correctly and did not complete wound care as ordered by R1's physician. In addition, during multiple observations on 2/10/25, R1 was observed in a recliner without heel boots.</p> <p>The failure to properly assess and monitor a new wound, implement pressure-relieving interventions, and transcribe a treatment order correctly led to a finding of immediate jeopardy that began on 1/29/25. Nursing Home Administrator (NHA)-A was notified of the immediate jeopardy on 2/24/25 at 1:45 PM. The immediate jeopardy was removed on 2/24/25, 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.</p> <p>Findings include:</p> <p>The facility's Pressure Injury Prevention and Wound Care Management Policy, revised 3/4/24, indicates: The facility will ensure that a resident who is admitted without a pressure injury does not develop a pressure injury unless clinically unavoidable and that a resident who has a pressure injury will receive care and services to promote healing and to prevent additional ulcers. Skin injuries (pressure and non-pressure) should be assessed weekly by the wound nurse or designee. Weekly documentation will include pertinent characteristics of existing ulcers, including location, size, depth, maceration, color of the ulcer and surrounding tissue, and a description of any drainage, eschar, necrosis, odor, tunneling or undermining. Documentation of wound characteristics will be completed using the Skin and Wound Assessment form. Wound and skin care interventions will be monitored and evaluated for effectiveness.</p> <p>(continued on next page)</p>		

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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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 2/10/25, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including peripheral vascular disease, type 2 diabetes, chronic obstructive pulmonary disease, chronic kidney disease, and congestive heart failure. R1's most recent Minimum Data Set (MDS) assessment, dated 1/27/25, noted a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated R1 had intact cognition. R1 made R1's own healthcare decisions.</p> <p>R1's comprehensive care plan, developed on 11/5/24, indicated R1 was at risk for alteration in skin integrity related to weakness, low body mass index (BMI)/weight loss, peripheral vascular disease, diabetes, anemia, congestive heart failure, chronic obstructive pulmonary disease, chronic kidney disease, and declining health status. Interventions for a pressure-relieving air mattress on bed and a pressure-relieving cushion for wheelchair were initiated on 11/5/24.</p> <p>Surveyor reviewed R1's progress notes, weekly skin assessments, and wound assessments for December 2024 to February 2025 and noted the following:</p> <p>~ A nursing progress note, dated 12/19/24, indicated ADON-C identified a skin concern for R1 and noted a small black dot with surrounding redness on R1's left medial foot. R1 was prescribed antibiotics for cellulitis. ADON-C (who was not wound care certified) classified the wound as arterial.</p> <p>There were no documented wound assessments until two weeks later.</p> <p>~ A Skin and Wound Evaluation, dated 1/2/25, indicated R1 had an in-house acquired left medial (arterial) foot wound that measured 2.8 centimeters (cm) x 2.3 cm x 1.6 cm that was present for two weeks and was healable. Nurse Practitioner (NP)-D determined the wound was arterial in nature.</p> <p>Nursing updated R1's care plan, and interventions to turn and reposition every two hours and monitor weights per facility policy were initiated on 1/2/25.</p> <p>~ A Skin and Wound Evaluation, dated 1/7/25, indicated R1 had a left medial (arterial) foot wound that measured 3.3 cm x 2.4 cm x 1.8 cm and was healable. The wound was noted to be stable despite its increase in size.</p> <p>~ From 1/11/25 to 1/13/25, R1 was hospitalized for pneumonia and a UTI. R1's left medial foot wound was assessed at the hospital on 1/13/25 and classified as an unstageable deep tissue injury (DTI).</p> <p>~ A Skin and Wound Evaluation, dated 1/14/25, indicated R1 had a left medial (arterial) foot wound that measured 3.2 cm x 2.6 cm x 1.6 cm. The wound bed was pink/red and R1 experienced intermittent pain with wound cleansing. Medical Doctor (MD)-E was notified and ordered a new treatment.</p> <p>~ A Skin and Wound Evaluation, dated 1/23/25, indicated R1 had an unstageable left medial (pressure) foot wound that measured 2.9 cm x 2.4 cm x 1.6 cm. The treatment was adjusted</p> <p>R1's care plan was revised on 1/23/25 and indicated R1 had a pressure injury on the left medial foot related to impaired mobility and functional ability. An intervention to have heel boots on at all times (may come off for transfers) was added on 1/23/25.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>~ A Skin and Wound Evaluation dated 1/29/25, indicated R1 had an unstageable left medial (pressure) foot wound that measured 1.9 cm x 2.1 cm x 1.1 cm and contained 20% slough and 80% eschar (dead tissue).</p> <p>~ A Wound Clinic Visit note, dated 1/29/25, indicated R1 had a stage 4 pressure injury on the left foot that measured 2.1 cm x 1.1 cm x 0.1 cm. Surgical excisional debridement removed 2.31 cm of devitalized tissue and necrotic muscle tissue. (The post-debridement assessment of the previously unstageable necrotic wound revealed underlying deep tissue at the muscle/fascia level which had been obscured by necrosis prior to that point.) The note indicated the wound was then classified as a stage 4 pressure injury. R1's dressing order was changed to apply Leptospermum honey and a gauze island dressing to be changed daily.</p> <p>~ A Skin and Wound Evaluation, dated 2/5/25, indicated R1 had a stage 4 left medial (pressure) foot wound that measured 1.6 cm x 2.1 cm x 1 cm and had light serosanguineous (blood-tinged) drainage</p> <p>~ A Wound Clinic Visit note, dated 2/5/25, indicated R1 had a stage 4 pressure injury on the left foot that measured 2.1 cm x 1.0 cm x 0.1 cm and contained light serosanguineous drainage. Surgical excisional debridement removed additional necrotic muscle tissue. R1's treatment was continued from the previous wound clinic visit.</p> <p>Surveyor reviewed R1's treatment administration records (TARs) for November 2024 to February 2025 and noted the following:</p> <p>~ From 11/1/24 to 1/12/25, R1 had an order for diabetic foot checks daily and to notify the provider of any concerns. Diabetic foot checks were documented as completed with no concerns identified.</p> <p>~ From 1/14/25 to 1/23/25, R1 had an order to apply Iodoflex to the left foot to aide in demarcation of eschar tissue followed by a foam dressing every 3 days and as needed. Every day shift every 3 day(s) for wound care and as needed.</p> <p>~ From 1/23/25 to 1/29/25, R1 had an order to apply Medihoney to the left medial foot wound, apply skin prep to the peri-wound, and cover with a foam border. Every day shift every other day for wound care and as needed.</p> <p>~ From 1/30/25 to the present, R1's TAR indicated to apply Medihoney to the left medial foot wound, apply skin prep to the peri-wound, and cover with a gauze island. Daily. Every day shift every other day for wound care. (Note: R1's TAR indicated the treatment was being completed every other day rather than daily as ordered by the wound clinic on 1/29/25.)</p> <p>On 2/10/25 at 9:43 AM, Surveyor observed R1 in a recliner without heel boots. Surveyor observed heel boots in the corner of R1's room. Surveyor interviewed R1 who stated R1 wore the heel boots at times and had no problem wearing them when offered.</p> <p>On 2/10/25 at 10:45 AM and 1:12 PM, Surveyor observed R1 in a recliner without heel boots.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 2/10/25 at 1:24 PM, Surveyor interviewed NHA-A regarding the assessment and treatment of R1's pressure injury. NHA-A stated ADON-C classified R1's left medial foot wound as arterial on 12/19/24. NHA-A verified ADON-C was not wound care certified. NHA-A also verified there were no documented wound assessments until 1/2/25 and no pressure-relieving interventions for R1's feet until 1/23/25. NHA-A stated when R1 came back from the hospital on 1/13/25, R1's left medial foot wound was re-classified as a pressure injury. NHA-A stated the facility identified deficiencies and initiated a past non-compliance plan on 1/20/25. NHA-A stated the facility completed skin sweeps for all residents and was in the process of completing audits to ensure wounds were identified and assessed and treatments were being completed as ordered. Director of Nursing (DON)-B verified R1's wound treatment was currently not being completed as ordered due to a transcription error. DON-B also indicated R1 was compliant with wearing heel boots.</p> <p>The failure to correctly identify, assess, monitor, and implement appropriate interventions for a resident at risk for pressure injuries led to serious harm for R1 which created a finding of immediate jeopardy. The facility removed the jeopardy on 2/24/25 when it completed the following:</p> <ol style="list-style-type: none"> 1. Educated staff on the Pressure Injury Prevention and Wound Care Management policy, specifically related to physician orders, documentation, treatment completion, implementation of care plan interventions, and how to access the Kardex (an abbreviated care plan used by nursing staff). 2. Conducted a skin sweep of all residents to ensure there were no new areas of skin alteration. 3. Conducted a chart audit of all residents with pressure injuries to ensure accuracy of physician orders, treatments were being completed, and care plan interventions were appropriate and effective. 4. Implemented a system where a second licensed staff is needed to confirm physician orders for accuracy. 5. Implemented skin and wound audits. 		