

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525641	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2025
NAME OF PROVIDER OR SUPPLIER Aspirus Care & Rehab-Medford		STREET ADDRESS, CITY, STATE, ZIP CODE 135 S Gibson St Medford, WI 54451	

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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not ensure implementation of person-centered care plan approaches for 1of 13 Residents (R1).</p> <p>This is evidenced by:</p> <p>The facility policy, titled Care Plan (Comprehensive, Temporary and Baseline) last reviewed 11/2020, states in part, The person-centered comprehensive care plan include: a) the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, and including the resident's strengths, goals, life history and preferences.</p> <p>R1 was admitted to the facility on [DATE] and has diagnoses that include multiple sclerosis, seizure disorder, paraplegia.</p> <p>R1's Quarterly Minimum Data Set (MDS) assessment, dated 4/23/25, indicated that R1 has a BIMS of 15/15, indicating cognitively intact, and is dependent on staff for mobility and ADLs, including positioning while in bed/wheelchair.</p> <p>R1's care plan, dated 4/29/25, states, I can't complete my cares on my own because I have multiple sclerosis with paraplegia. Approach includes having a lateral support to use in the left side of wheelchair - whether it be a wedge, a rolled blanket, a pillow, etc.</p> <p>On 06/02/25 at 1:35 PM, Surveyor observed R1 leaning heavily to left side while in wheelchair with a loosely folded up blanket in place which was not maintaining upright positioning of R1.</p> <p>On 06/03/25 at 7:03 AM, Surveyor observed R1 in a motorized wheelchair leaning heavily to left side attempting to correct position independently but was unable to maintain upright position. Surveyor asked if R1 was comfortable. R1 stated, No, they don't have my wedge cushion in. I don't know where it is. R1 stated, I wish they would hurry up and get wedge.</p> <p>On 06/03/25 at 7:21 AM, Surveyor interviewed Certified Nursing Assistant (CNA) D regarding positioning devices for R1. CNA D stated, Yes, [R1] has a wedge cushion that should be in place. Did they forget? CNA D repositioned R1 with wedge cushion along left side and R1 confirmed feeling better.</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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 06/04/25 at 7:25 AM, Surveyor interviewed CNA C on how staff are informed of proper repositioning devices to use for R1. CNA C showed Surveyor R1's CNA care plan hanging in closet which indicated use of wedge cushion for positioning.</p> <p>On 06/04/25 at 10:52 AM, Surveyor interviewed Director of Nursing (DON) B regarding expectations of implementing care plan approaches. DON B confirmed expectation of staff is to follow resident care plans.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**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 (R) received treatment and care in accordance with professional standards of practice for 1 out of 13 residents sampled. (R172)</p> <p>The facility did not follow provider's orders, or the facility wound assessment procedures for R172, who was needing care and treatment for a post operative surgical wound.</p> <p>Findings include:</p> <p>The facility's policy titled, Pressure Ulcers and Other Wound Procedure last revised on 03/2023 states in part, . 2. Assessment 1. Frequency .b. A total skin assessment will be done on admission and weekly x 4 by a licensed nurse.</p> <p>R172 was admitted on [DATE] from the hospital with a pertinent diagnosis of hemiarthroplasty hip partial status post age related osteoporosis with fracture of the right femoral neck (this diagnosis was added to R172's record on 6/3/25- effective 5/29/25). Bilateral below the knee amputation, post hemorrhagic anemia, kidney disease- chronic, Type II diabetes w/ peripheral, long term use of insulin, anxiety disorder, and depression.</p> <p>R172's admission Minimum Data set (MDS) was not yet completed. Completed due date would be 6/5/2025.</p> <p>R172's care plan did not include wound care for R172's right hip incision status post hemiarthroplasty done on 5/25/25 at time of State Agency (SA) review on 6/2/25 and was not added to care plan until 6/4/2025.</p> <p>R172 had no documentation for surgical wound assessment, care, or treatment at the time of SA review on 6/2/2025.</p> <p>R172's hospital discharge after visit summary states, in part, Wound/incision care: keep incision clean and dry. Special instructions: call your doctor if you have any of these symptoms: . Increased pain not relieved by medication, Fever over 101 degrees for 24 hours, Increased redness/swelling around incision . Orthopedic discharge instructions: .Remove dressing in 7 days, ok to shower and leave incision uncovered if there is no drainage.</p> <p>On 6/02/25 at 10:19 AM, Surveyor interviewed R172, who reported a patch on right hip surgical site. R172 stated, As far as I can remember, they (facility staff) have not changed bandage or even looked at it, since admission on [DATE]. R172 showed Surveyor right hip area. Surveyor noted a white dressing approximately 4 x 10 adhered to R172's outer hip. Surveyor noted no redness, odor, drainage, or swelling. R172 reported minimal pain.</p> <p>Surveyor did a brief record review noting R172 had no diagnosis or orders for a post operative incision.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/02/25 at 12:24 PM, Surveyor interviewed Registered Nurse (RN) F, who stated she is not able to find any orders for incision care or documentation of R172's wound assessment since R172's admission on [DATE]. RN F stated, It should be in there. I will put it in there right now. RN F stated she would have expected an assessment with documentation of the incisional site and dressing change.</p> <p>On 6/02/25 at 1:48 PM, Surveyor interviewed RN F who reported she found R172's after-visit summary with surgical site directions. RN F stated R172's outer dressing was supposed to be removed in 7 days, which would have been yesterday, 06/01/2025. RN F reported she just removed R172's outer white dressing and assessed surgical incision. No concerns noted with incisional site and wound has a clear protective covering over it. RN F reported she was going to document on the wound before she leaves at the end of her shift today. Director of Nursing (DON) B came to nurses' desk during interview. DON B was updated by RN F regarding R172's lack of assessment and documentation of surgical wound. DON B stated, I will have to look into this.</p> <p>On 6/04/25 at 7:41 AM, Surveyor interviewed DON B, who stated the expectation of the facility nurses is to do a complete skin assessment on every resident upon admission. DON B stated when she asked the admitting nurse about the admission assessment, staff missed identifying R172's surgical incision.</p> <p>On 06/04/25 at 11:56 AM, Surveyor interviewed DON B after reviewing admission checklist. DON B acknowledged that because no wound was identified upon R172's admission, there was no treatment record with daily wound checks or skin care plan completed. DON B agreed there was no incisional site assessment or care performed or documented since R172's admission on [DATE] until 6/2/25. DON B stated the expectation is that professional standards of practice for incisional wounds would have been followed by facility nurses. DON B agreed that daily assessments would include dressing placement, assessing for bleeding and signs and symptoms of infection. DON B stated R172's discharge summary orders/after visit summary should have been followed by facility and was not.</p>		