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 04/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspirus Care & Rehab-Medford	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)
F 0686 Level of Harm - Minimal harm or potential for 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** Based on observation, interview and record review, the facility did not ensure that 2 of 2 residents (R) reviewed for pressure injuries (PI) (R7 and R30) received care consistently with professional standards of practice to prevent further deterioration and promote healing of an existing PI.R7 and R30 were at risk for PI development. The facility failed to provide complete comprehensive weekly assessments with staging of the PI. This is evidenced by Example 1 The standard of practice for staging pressure injuries is based on the NPIAP (National Pressure Injury Advisory Panel) system, which categorizes injuries from Stage 1 to Stage 4, along with Unstageable and Deep Tissue Pressure Injury (DTPI). Staging is based on the anatomical depth of tissue destruction (epidermis, dermis, muscle, bone). Facility's policy titled Pressure Ulcers and other Wounds Procedure effective date of 03/2023, documented in part. 2. Assessment .3. Characterize the wound and pressure ulcer when documenting. a. Document pertinent characteristics of existing pressure ulcers and other wounds including: i. Location, size depth, maceration, color, description of drainage, eschar, necrosis, odor, tunneling, undermining, tissue types, description of periwound. R7 was admitted to the facility on [DATE]. R7's diagnoses include palliative care, Parkinson's disease and heart failure. R7's admission Minimum Data Set (MDS), dated [DATE], documented a brief interview for mental status score of 7/15, meaning severe cognition impairment. R7 is dependent on staff to shower/bathe, lower body dressing, and personal hygiene. R7 is at risk of developing pressure injuries, with one stage 3 PI present on admission. On 01/19/26, a skin breakdown assessment was completed with a score of 17. A score of 15-18 is at mild risk for skin breakdown. Physician orders:03/06/26 treatment: Skin: Cleanse 2nd Right toe, Apply wet to dry dressing once daily. Remove dry, until resolved. Leave right shoe off if resident allows daily AM. 03/10/26 Treatment: Skin: Document on ulcer to right 2nd toe until resolved one time per week Wednesday AM FIRST Date: 01/21/26 Care Plan: 02/05/26 I: Have a skin injury. Because I: have an ulcer to my right 2nd toe.I need my nurses to Complete treatment as ordered. Update myself/responsible party as needed. Update (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 - Minimal harm or potential for actual harm Residents Affected - Few	Hospice as needed. I need my aides to report soiled or missing bandages to my nurse to be replaced. My goal is to : avoid infection Goal time: Three months Surveyor observed R7's right second toe on 04/07/26 at 9:22 AM when Registered Nurse (RN) C completed wound care. R7's toe appeared to have the tip of the toe curled down. The PI was dry with the wound bed with 100% eschar and with dark to black area on the left side of the toenail and under the toenail. R7's admission skin assessment dated [DATE] documented in part open lesion on foot, 2nd toe, right foot, Description: moist, macerated, fragile, non blanchable. Size: length (cm) 1.5, width (cm) 1.5, Drainage: Sero-sanguious, pink wound bed with white surrounding tissue. On 01/28/26, a weekly skin assessment documented No changes in appearance to the ulcer on right 2nd toe, remains pink and slightly moist. On 02/04/26, a general skin condition note, Right foot second toe, moist open area with bright pink wound bed, the edges are slightly rolled in and has some white tissue, size 1.4 cm x 1.5 cm, scant amount of sero-sanguious. On 02/11/26, a general skin condition note, Right foot second toe, moist open area with bright pink wound bed, some white tissues noted towards the edges, 1.4 cm x 1.5 cm, no drainage. On 02/18/26, no assessment of right foot second toe. On 02/25/26, a weekly skin assessment, Right foot second toe open area, the wound bed is dark brown and dry. The wound edges are slightly rolled in and slightly raised, 1.3 cm x 1.3 cm, no drainage. On 03/04/26, Right foot second toe, the edges are a little swollen and tender to the touch. The wound edges are also slightly rolled in and are pink. Wound bed has some white tissue, and the other part is dark brown, 1.4 cm x 1.4 cm, no drainage has pain to wound site. On 03/11/26, Right foot second toe 1 cm x 0.6 cm, sero-sanguious drainage, it appeared to have a small spot of yellow drainage noted under the corner of the toenail. On 03/18/26, Right 2nd toe, small open area, dry, red wound base, calloused built up areas surrounding open area, 1 cm x 0.5 cm x 0.2 cm depth, and no drainage. On 03/25/26, Right 2nd toe, size n/a, sero-sanguious drainage, yellow. On 04/01/26, Right 2nd toe, area around the nail is reddened, fragile, some scabbing noted. End of toe has eshar(sic) to wound bed, reddened skin around wound, white macerated tissue to planter side of wound, some serous drainage noted to dressing upon removal. Size n/a, and serous drainage. On 04/06/2026 at 1:27 PM, Surveyor interviewed Registered Nurse (RN) C and Director of Nursing (DON) B about R7's wound assessment to include staging and weekly measurements. RN C stated is wound care certified. RN C doesn't do much with staging and has no charting of staging of R7's PI. The area was scabbed filled for the vast majority of the time. DON B stated this would be unstageable. Surveyor asked when the area became unstageable. RN C stated there was a period of (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	time on admission that was not scabbed over. Surveyor asked what the stage of the PI was at that time. RN C stated 2-3 if had to stage on admission, at that time it had a red wound bed. RN C stated she did not stage the wound, the MDS nurse staged the wound. Surveyor asked if MDS nurse observed the PI. RN C stated MDS nurse did not see the PI. RN C stated RN C would see the PI regularly to judge if it is getting larger. The PI is assessed every bath day that is every seven days. The hole itself has not changed much. The second toe is bent down so the tip of the toe is touching the floor and this is where the PI is located. On 04/07/2026 at 9:38 AM, Surveyor interviewed RN D, the MDS nurse, asking about R7's PI staging. RN D stated will look at the wound on the reference date and assess. Will talk with the nurses and DON B and talk about the stage of the wound. Nursing would document the PI on admission and chart what they see. Typically, the nurses don't put the stage on the assessment. We knew about the PI before R7 came to the facility. Felt it was a PI but R7 does have multiple factors that contribute to the wound like diabetes and pvd. On 04/07/2026 10:05 AM, Surveyor interviewed Nursing Home Administrator (NHA) A about assessing and staging of PIs. NHA A felt RN C was doing good at assessing the PI weekly. Surveyor reviewed with NHA A of the assessments not being comprehensive to include description of location on toe, the amount of slough or eschar in the wound bed, the stage of the PI on the admission and weekly assessments, and missing measurements on two weekly assessments. NHA A stated understanding of needing staging of the PI on the assessments and accurate assessments. Example 2 Based on National Pressure Injury Advisory Panel (NPIAP): Calazime is suitable for application on denuded or weeping skin around a pressure injury to promote skin integrity.Instead of paste, the NPIAP typically recommend moisture-retaining dressings for Stage 2 wounds to promote healing, such as hydrocolloids: for low-exudate Stage 2 injuries. Foam dressings: for moderate-exudate Stage 2 injuries. Hydrogels: for dry-to-low exudate wounds. R30 was admitted to the facility on [DATE], after a hospitalization for exacerbation of congestive heart failure. R30's diagnoses included Stage 2 Pressure Ulcers to right and left buttock, per the hospital discharge summary. R30's Minimum Data Set (MDS) assessment was to be completed by 04/07/26. Surveyor was not able to review complete MDS data. R30's wound care notes from the hospital, dated 03/30/26 included diagnoses of Stage 2 Pressure Ulcers to left and right buttock. R30's skin assessment on 04/02/26 included: Coccyx, two left buttock pressure ulcers measuring 1.7cm x 1.7cm and 0.5cm x 1.6cm. Both ulcers appear epithelized with blanchable periwound, no signs of infection and no drainage. Note, skin assessment was not comprehensive and did not include staging of pressure ulcers. R30's wound orders included the following: 04/02/26, Buttock ulcer, apply barrier cream with calazime to area twice daily and as needed, do not cover with bordered foam. Right hip, cleanse with vashe, apply xeroform and bordered foam, change three times weekly and as needed. Check two left buttock pressure ulcers daily. Document two left buttock pressure ulcers weekly. Note, skin (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessment did not indicate a wound to right hip or right buttock. Note, R30 did not have a diagnosis of two pressure ulcers to left buttocks upon discharge from the hospital, R30 diagnosis included Stage 2 Pressure Ulcers of left and right buttocks. On 04/07/26 at 9:57 AM, Surveyor interviewed Registered Nurse (RN) E. RN E reported she was not sure where R30's wounds were located, and she would be administering R30's wound care today. On 04/07/26 at 10:05 AM, Surveyor interviewed Certified Nursing Assistant (CNA) F. CNA F reported she assisted R30 this morning with cares and did not note any dressings to R30's hip or redness to buttocks or hips. On 04/07/26 at 10:11 AM, Surveyor interviewed R30. R30 reported having an open area to her buttock. R30 denied any wounds located on her hips. R30 stated she did not think the facility staff was applying any dressings to her hip or buttock. On 04/07/26 at 10:17 AM, Surveyor interviewed Director of Nursing (DON) B. DON B was unable to report the reason R30 had a wound treatment order for her right hip. DON B was unable to report if R30 had a treatment order for Stage 2 Pressure Ulcer to right buttock. DON B was unaware if R30 had one or two pressure ulcers to her left buttock. Surveyor asked DON B if R30's wound treatment orders followed a standard of practice for treatment of a Stage 2 Pressure Ulcer. DON B stated she would review R30's record. On 04/07/26 at 10:28 AM, Surveyor observed RN E administer R30's wound care. Surveyor observed R30 had a foam border dressing to her right lower hip, dated 04/05/26. RN E removed the dressing and noted a dark purple colored area, it appeared closed, without redness or drainage. RN E ran a gloved finger over the area and stated this area was indented and a Stage 2 Pressure Ulcer to right buttock or right hip. Surveyor observed that R30 had a pressure ulcer to inner left buttock, area was open and dark pink in color, moist, with small amount of serosanguinous drainage. The skin around the open area was flat, without redness or signs of infection, and darker in color, evidence of wound chronicity. RN E placed a foam dressing to area. RN E stated she would update the wound care nurse as the pressure ulcer to R30's left buttock, looks different today than the other day. On 04/17/26 at 11:00 AM, Surveyor interviewed DON B. DON B stated she thought the nurse who completed R30's admission skin assessment made a mistake and documented R30 had two pressure ulcers to left buttock and meant to document a pressure ulcer to both left and right buttock. Surveyor could not determine if R30's pressure ulcers had worsened due to inaccurate documentation and R30's limited time in the facility. Surveyor determined the following: R30's initial skin assessment was not comprehensive and was inaccurate. The facility's documentation did not support any areas of concern to R30's right buttock or hip, however R30 had a wound treatment order for right hip. The wound treatment order to R30's Stage 2 Pressure Ulcer to left buttock did not follow standards of practice for the condition of the wound.