STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525647	A. Building B. Wing	05/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evergreen Health Center	1130 N Westfield St Oshkosh, WI 54902

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. Based on observation, staff interview, and record review, the facility did not ensure 1 resident (R) (R10) of 2 sampled residents received the necessary care and services to prevent pressure injuries from developing and/or promote healing. R10 had an air mattress that was implemented on 7/16/24. The mattress was not set to R10's current weight. R10's medical record did not contain an order to check the mattress settings or ensure the mattress was set appropriately. Findings include: The facility's Skin Care and Pressure Injury Management policy, revised 12/18/25 and based on the National Pressure Injury Advisory Panel (NPIAP) Quick Reference Guide, indicates: .Stage 1 Pressure Injury: Intact skin with an area of non-blanchable erythema .Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroondiscoloration; these may indicate deep tissue pressure injury .2. Interventions: .K. Low air loss mattress if available; Stage 2 Pressure Injury: Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is notvisible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present .commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel .2. Interventions (in addition to those listed under stage 1): A. Initiate low air loss mattress if available. Medline Max-Air Air Mattress manufacturer's instructions for the Advanced Low Air Loss mattress indicate: .3. Check resident weight for appropriate firmness setting . Between 5/26/26 and 5/27/26, Surveyor reviewed R10's medical record. R10 was admitted to the facility in 2020 with diagnoses including Alzheimer's diseaase, weight loss, and osteoporosis, R10 had a current stage 3 pressure injury (deep wound characterized by full-thickness skin loss where subcutaneous fat is visible) on the sacral region. R10's Minimum Data Set (MDS) assessment, dated 5/6/26, stated R10 had a Brief Interview for Mental Status (BIMS) score of 5 out of 15, indicating severely impaired cognition. The MDS assessment indicated R10 had an unhealed stage 3 pressure injury and had a pressure-reducing device for bed. A care plan, dated 4/5/26, indicated R10 had impaired skin integrity and wounds related to decreased mobility, bladder incontinence, history of steroids, history of stage 2 pressure injury on the coccyx, and the inability to consistently reposition in bed and chair. On 4/5/26, R10 was noted to have moisture-associated skin damage (MASD) on the coccyx. On 4/16/26, R10 was noted to have a stage 3 pressure injury. R10 was more restless and confused and slid down in the recliner which resulted in shearing of the skin. The care plan contained a goal that R10 would remain free of further skin breakdown and R10's stage 3 coccyx pressure injury would resolve without complication over the next 90 days. The care plan contained an intervention to administer/monitor effectiveness of skin-related treatments and for signs and symptoms of wound infection. An air mattress was provided on 7/16/24 .Medline air mattress setting: See care sheet for current setting. On 5/26/26 at 2:40 PM, Surveyor interviewed Certified Nursing Assistant (CNA)-J and asked CNA-J to observe R10's air mattress. Surveyor and CNA-J noted R10's air mattress was set at 10 (which was the most firm setting). This was evidenced by 9 green lights and a 10th light that was red. CNA-J felt the mattress and stated the air mattress was working. CNA-J stated CNAs do not adjust air mattress settings and indicated nurses are responsible for adjusting mattress settings. CNA-J stated CNAs observe and (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	check air mattresses for inflation, listen for alarms that activate due to malfunction, and inform nurses of any concerns. CNA-J stated air mattresses contain stickers with weight ranges and the corresponding settings. Setting 10 was indicated for a weight of 400 pounds or greater. On 5/26/26 at 3:26 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-I who verified R10's care sheet, Treatment Administration Record (TAR), and physician orders did not contain an air mattress setting. LPN-I stated air mattress settings are documented under treatments in the medical record and staff have to document when they check the setting and that the mattress is working. Between 4/27/26 and 5/25/26, R10's weights were documented between 130.6 pounds and 138 pounds. R10's medical record contained the following orders: ~ 4/6/26 to 4/16/26: Wound care to open area on coccyx: Apply remedy protect barrier cream every shift and as needed to coccyx for moisture-associated skin damage (MASD)~ 4/16/26 to 4/30/26: Wound care once daily to coccyx: Apply skin prep to peri wound, cover with bordered foam, change daily and as needed~ 4/19/26: Update MD every two weeks with progress of coccyx wound~ 4/30/26: Wound care to coccyx: Cleanse with normal saline or wound cleanser, apply skin prep to peri wound, follow with silver alginate (absorbent antimicrobial wound dressing) to wound base, cover with bordered foam, and change daily and as needed On 5/27/26 at 8:28 AM, Surveyor observed R10 in the dining room in a wheelchair. Surveyor observed R10's air mattress and noted it was still set at 10. On 5/27/26 at 9:42 AM, Surveyor and Director of Nursing (DON)-B observed R10's air mattress and noted the mattress was set at 10. DON-B stated R10's care card should contain an air mattress setting. DON-B stated R10's air mattress should be set lower than 10 and DON-B would have it set appropriately per R10's weight. DON-B stated Bath Aide (BA)-K weighs residents on their bath days and sets air mattresses accordingly. On the way to interview BA-K at 9:47 AM, DON-B asked Certified Occupational Therapy Assistant (COTA)-L about weights and air mattress settings. COTA-L stated BA-K sets air mattresses. On 5/27/26 at 9:49 AM, DON-B and Surveyor interviewed BA-K who stated BA-K weighs residents but does not check air mattress settings. On 5/27/26 at 2:21 PM, Surveyor observed R10's air mattress which was set at 5 (150 pounds). On 5/27/26 at 2:23 PM, Surveyor interviewed CNA-G who stated CNA-G had not changed R10's air mattress setting. CNA-G stated bath aides set air mattresses by residents' weights. On 5/27/26 at 2:26 PM, Surveyor again interviewed DON-B who reviewed R10's coccyx wound timeline with Surveyor which indicated an air mattress was implemented for wound prevention on 7/16/24. R10 had a previous stage 2 pressure injury on the coccyx which had healed and closed. R10's coccyx wound re-opened on 4/24/25. R10's coccyx wound healed on 5/8/25. R10's coccyx wound re-opened on 4/5/26 and was currently a stage 3 pressure injury. DON-B stated an air mattress should be set in accordance with a resident's weight and verified R10's medical record and plan of care did not contain an air mattress setting. DON-B stated all air mattresses were checked on 5/11/26 during a facility-wide audit.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff and resident interview, and record review, the facility did not establish and maintain an infection prevention and control program designed to prevent the development and transmission of communicable disease and infection for 3 residents (R) (R1, R5, and R10) of 4 sampled residents.R1 had a presure injury on the sacral region but was not on enhanced barrier precautions (EBP). In addition, staff completed wound care for R1 without wearing gowns.R5 had an indwelling catheter and was on EBP. Staff provided care for R5 without wearing gowns or gloves. In addition, R5's catheter bag was on the floor.R10 had a pressure injury on the sacral region and was on EBP. Staff transferred R10 without wearing gowns or gloves. Findings include: The facility's Infection Control Program, dated 11/25/25, indicates: .Enhanced barrier precautions (EBP): 1. EBP is used in addition to standard precautions when contact precautions do not apply. 2. Personal protective equipment (PPE) to include gloves and gowns (mask and goggles or face shield if splash potential is present) during high-contact resident care activities .5. Facility will implement EBP for residents with current or history of multidrug-resistant organisms (MDROs) targeted by the Centers for Disease Control and Prevention (CDC) as listed below. The facility will also implement EBP for residents with wound or indwelling medical devices, regardless of MDRO colonization . The facility's Indwelling Urinary Catheters policy, dated 7/25/24, indicates: .Indwelling Urinary Catheter Care: .Maintain proper position of the catheter, the drainage bag, and the collection tube. The drainage bag should be below the level of the bladder. This will promote drainage and prevent urine from sitting in the collection tubing or moving back into the bladder. The bag should never touch the floor . 1. On 5/27/26, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including malignant neoplasm of prostate and pressure ulcer of sacral region. R1's Minimum Data Set (MDS) assessment, dated 4/30/26, stated R1 had Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating intact cognition. On 5/27/26 at 12:15 PM, Surveyor also observed Registered Nurse (RN)-D and Certified Nursing Assistant (CNA)-F complete a dressing change for R1's unstageable pressure injury. RN-D and CNA-F did not wear gowns during wound care. Surveyor noted there was not an EBP sign on or near R1's door to alert staff of the need to wear personal protective equipment (PPE) during high-contact cares. On 5/27/26 at 2:22 PM, Surveyor interviewed Director of Nursing (DON)-B and Assistant Director of Nursing (ADON)-C who verified R1 should have been on EBP related to the unstageable pressure injury. ADON-C indicated R1 changed rooms on 5/11/26 and R1's wound was noted to be unstageable on 5/15/26. ADON-C indicated staff should have followed EBP from that date forward. 2. On 5/27/26, Surveyor reviewed R5's medical record. R5 was admitted to the facility on [DATE] and had diagnoses including dementia, retention of urine, and chronic kidney disease. R5's MDS assessment, dated 4/21/26, stated R5 had a BIMS score of 10 out of 15, indicating moderately impaired cognition. On 5/26/26 at 11:20 AM, Surveyor observed CNA-E toilet R5 and transfer R5 from the wheelchair to a (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	recliner. CNA-E did not wear PPE while providing care. Surveyor noted a sign outside R5's room that indicated R5 was on EBP and PPE was required when providing personal care and transfers. At 11:21 AM, Surveyor interviewed R5 who complained about the urine odor in R5's room and indicated it was related to R5's night time catheter bag which was placed on the floor and leaked. On 5/26/26 at 11:36 AM, Surveyor interviewed CNA-E who indicated CNA-E should have worn PPE to toilet and transfer R5 but forgot. On 5/27/26 at 8:29 AM, Surveyor interviewed CNA-E who indicated when CNA-E entered R5's room, R5 was sitting in the recliner and R5's catheter bag was on the floor. CNA-E indicated a catheter bag should not be on the floor. CNA-E was not aware of a urine leak but acknowledged R5 had a different night bag from the previous day. CNA-E was not sure if the bag was changed due to leakage. On 5/27/26 at 12:55 PM, Surveyor interviewed DON-B who indicated staff should wear PPE during direct contact for a resident on EBP. DON-B verified a catheter bag should not be on the floor. DON-B was not aware of a urine smell in R5's room and entered a work order for the carpet to be cleaned. 3. Between 5/26/26 and 5/27/26, Surveyor reviewed R10's medical record. R10 was admitted to the facility in 2020 with diagnoses including Alzheimer's disease and osteoporosis. R10 had a current stage 3 pressure injury (a wound characterized by full-thickness skin loss where subcutaneous fat is visible) on the sacral region. R10's MDS assessment, dated 5/6/26. stated R10 had a BIMS score of 5 out of 15, indicating severely impaired cognition. R10's medical record contained a care sheet that indicated R10 was on EBP. On 5/26/26 at 2:52 PM, Surveyor observed CNA-G and CNA-H transfer R10 from wheelchair to toilet via sit-to-stand lift. CNA-G did not wear a gown or gloves. CNA-H did not wear a gown while transferring R10 to the toilet or completing personal hygiene care for R10 after toilet use. On 5/26/26 at 3:01 PM, Licensed Practical Nurse (LPN)-I entered R10's room wearing a gown and gloves to complete wound care. On 5/26/26 at 3:04 PM, CNA-G and CNA-H exited R10's room. CNA-G and CNA-H re-entered the room at 3:06 PM wearing gowns and gloves and transferred R10 back into the wheelchair after LPN-I completed wound care. On 5/26/26 at 3:27 PM, Surveyor interviewed CNA-G regarding the facility's EBP policy. CNA-G stated CNA-G and CNA-H should have been worn gowns and gloves while transferring and toileting R10. CNA-G stated CNA-G did not realize R10 was on EBP. CNA-G acknowledged the EBP sign posted at the entrance of R10's room and the PPE cart next to R10's door. CNA-G indicated staff are expected to wear PPE during transfers and toileting for residents on EBP. On 5/27/26 at 10:00 AM, Surveyor interviewed DON-B who stated staff are expected to wear gowns and gloves during transfers and cares for residents on EBP.