STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525687	A. Building B. Wing	07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pigeon Falls Hcc	13197 Church St Pigeon Falls, WI 54760

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview and record review, a resident's medication order was not limited to 14 days, and prescribing practitioner did not document the rationale for the extended time use or a specific duration for use for 1 of 2 sampled residents, (R) R21, reviewed for PRN (as needed) psychotropic medications. R21 was prescribed PRN Hydroxyzine for anxiety on 06/06/2025; there was no rationale for extended use written and no specific duration for use.This is evidenced by: R21 was admitted to the facility in 2016 and has diagnoses that include anxiety disorder, vascular dementia, cerebral infarct, depressive disorder, dysphagia and aphasia. R21's physician order dated 06/06/25 states: Hydroxyzine 25mg as needed two times a day for anxiety. Review of R1's medication administration record (MAR) revealed R1 used Hydroxyzine 25mg for anxiety on 06/07/25, 06/09/25, 06/13/25, 06/16/25, 07/01/25, 07/02/25, 07/17/25, and 07/22/25. On 07/21/25-07/23/25, Surveyor reviewed R21's medical record and was unable to locate a rationale for the extended use for the as needed Hydroxyzine and did not locate a specific duration for its use. On 07/23/25 at 11:20 AM, Surveyor requested the facility policy and procedures on as needed psychotropic medication use and further information related to R21's PRN medication use. At 12:35 AM, Director of Nursing (DON) B stated she could not find any further information related to R21's medication use. DON B stated the facility does not have a specific policy and procedure related to this; they refer to the regulations.

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not ensure that the resident received treatment and care in accordance with professional standards of practice of comprehensive weekly wound assessments for 1 of 1 resident (R) 5 reviewed. This is evidenced by:R5 was admitted to the facility on [DATE]. R5's current diagnoses include in part, non-pressure chronic ulcer of left lower leg and long term use of anticoagulants. Minimum Data Set (MDS) dated [DATE] a quarterly assessment documented a brief interview for mental status (BIMS) score of 15/15, meaning R5 is cognitively intact. R5 had no impairment to all extremities and is independent with activities of daily living. R5 is not at risk for pressure injuries. On 05/01/25, a Braden assessment for risk of pressure injury was completed with a score of 21. A score of 19 or higher the resident is not at risk for pressure injury. Physician orders document on 07/18/25 Change dressing to L lower leg area. Cleanse wound with cleanser, Apply collagen particles and Hydrogel gauze. Cover with Silicone bordered gauze. Wrap with gauze roll and secure with tape. Tubigrips size G applied to bilateral legs, then 2 ace wraps to be applied to R foot/ankle area then a 3rd up to knee. 2 to be applied on LLE. Special Instructions: .Once A Day, 07:00 - 12:00A comprehensive care plan was not developed to address the open wound. The progress notes documented: On 05/06/25 10:06 PM, Resident approached nurses tonight to provide a dressing to his L lower leg (anterior aspect), which is blistered and weeping from the edema. ABD pad and Kerlix dressing applied to area at this time. Encouraged resident to elevate legs and let staff know when dressing becomes saturated in order to keep area clean and dry. Surveyor noted no comprehensive assessment with size and description of the wound was completed at the time of development and weekly. The first assessment with measurement was completed on 06/06/25, [R5] had dressing changed this AM. LLE had scant drainage noted. Excoriated area measures like 5cm L x 2cm W. Another small area to the lateral side of bigger area. Applied dressings as ordered. Area is not red or warm to touch.On 06/12/25, [R5] was seen by [Name] Wound Specialist at this time. Dressing order changed per [name wound specialist] to super absorbent 4x4 verses ABD pad. Continue with collagen and cover with gauze wrap. Dressing to be changed daily. New dressing applied per order. On 06/13/25, [R5] approached this writer about 1600. Requested that the wraps be removed, dressing also removed. It was saturated at this time. Ace wrap wet. Explained that the moisture does aid in healing also. Excoriation measures 4cm x 3cm on medial side of leg, with smaller 2cm x 2cm area on lateral side of leg. On 06/21/25, Dressing change completed to LLE. Old dressing was sticking some to wound. Needed wound saline spray to help this detach. Area measured and wound assessed. Wound looks more superficial pink/red in color. Drainage had some scant bleeding noted. Medial wound is 5cm L x 3.5cm W at top widest area, at bottom 5cm L x 3cm W. Lateral wound measures 2. 5 cm L x 2.3cm W, with 2 small areas to the inner side of medial wound measuring 0.5cm x 0.5cm.On 06/27/25, Measurements noted this AM of LLE wound. Middle one measures 5.6cm x 4.2cm. Smaller L medial area is 0.6cm x 0.8cm, with one to Lateral side measuring 2.8cm x 2.7cm.On 07/05/25, Skin check completed. Skin is intact. Areas to lower left shin measures 3.9 x 3.5 on inner open area and 3cm x 2cm to outer open area. Areas are deeper. Areas are red. No warmth noted. Edema 4+ to both lower extremities. Encouraged to elevate and reduce sodium intake. On 07/07/25, Dressing change completed. R5 complained of some increased pain in wound. Dressing was sticking to wound. Area sprayed with wound cleanser to release the dressing well. Cleansed well, applied new dressing as tolerated. PTA was there completing the massaging of legs. Placed ace wraps on as before. Questioned as the other day had switched to tubigrips. This was due to him going out, so she was going to check on this further. Measurements completed and was 5.5cm x 5.5cm with an area on the lateral side of leg measuring 2.5cm W x 4cm L. Redness is surrounding like 3cm, No real increased warmth noted. Referral sent to the Wound center at Mayo today per R5's request. Did update our wound certified resource person to see about him coming in to see it. Will update provider also. On 07/17/25 [R5] was seen today by [Name] WCC [Name] New orders received and carried:Change dressing to L lower leg area. Cleanse wound with cleanser, Apply collagen particles and Hydrogel gauze. Cover with Silicone bordered gauze. Wrap with gauze roll and secure with tape.Surveyor noted the facility did not have weekly wound assessment completed between 07/07/25 until 07/20/25. On 07/20/25, This RN concurs with skin observation completed. Measurements completed on LLE wound. Medial wound is 3cm x 1.5 at largest area toward bottom, rest is about 1cm wide. Lateral wound measures 3. 8cm x 1.3cm. Granulation tissue is present. Less pain with dressing change noted. Edema is going down. No

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(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. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not ensure 1 of 2 residents (R) reviewed for pressure injuries (PI) received care consistent with professional standards of practice to prevent the development of a new pressure injury and promote healing of existing PIs (R8).R8 developed one medical device related PI on 05/20/25. The facility did not have preventive measures to reduce friction related to medical device in place. The facility did not complete weekly comprehensive assessments with staging of the PI upon discovery and did not care plan new interventions timely to promote healing.This is evidenced by:Facility policy titled, Pressure Ulcers, Prevention & Treatment, with a reviewed date of 01/2025, states in part: General Guidelines of Prevention: 3. Pressure can also come from splints, casts, bandages, and wrinkles in the bed linen. If pressure ulcers are not treated when discovered, they quickly get larger, become very painful for the resident/client, and oftentimes become infected.Interventions and Preventative Measures: Residents with Risk Factors: 2. Risk Factor - Friction and Shear: h) monitor the placement of splints and casts to assure they are not placing friction on the resident/client's skin. k) Contractures need to be addressed and managed to prevent skin integrity disruption.Staging Protocols: Stage 1 Pressure Ulcer Interventions/Care Strategies. 1. Pressure: a. Determine cause of pressure and relieve. b. Redistribute pressure. c. Implement pressure-relieving device(s) in accordance with resident/client's assessed needs.Monitoring Pressure Ulcers: A. Daily monitoring. 1. Evaluate ulcer if no dressing is present. 3. Status of area surrounding ulcer that can be observed.B. Weekly or Dressing Change Monitoring: 1. Location and staging of ulcer. 2. Size, depth, and presence, location, and extent of undermining or tunneling. 3. Presence of exudate; if present, type (e.g., purulent, serous), color, odor, approximate amount. 4. Presence of pain. 5. Status of wound bed: color and type of tissue; evidence of healing; necrosis. 6. Description of wound edges and surround tissue (e.g., rolled edges, redness, hardness/induration, maceration). 7. Interventions and care plan approaches.R8 was admitted to the facility on [DATE] with pertinent diagnoses of cerebral infarction due to thrombosis of right middle cerebral artery, acute myocardial infarction, meiplegia and meiparesis following cerebral infarction affecting left non-dominant side, and diabetes mellitus type 2.R8's quarterly Minimum Data Set (MDS) assessment, dated 05/08/25, noted a Brief Interview for Mental Status (BIMS) score of 15/15 indicating cognition is intact. No PI is present and no other wounds present. Range of Motion (ROM) in upper and lower extremities have impairment on one side, dependent assist needed for oral hygiene, toileting hygiene, shower/bathe self, upper/lower dressing, footwear, personal hygiene, roll left to right, sit to lying, chair/bed transfer, and toilet transfer. Physical therapy service start date of 04/28/25 and restorative nursing program 7 days a week for active ROM and passive ROM.R8's care plan, dated 05/13/25, with a target date of 08/14/25, states: I want to keep my left foot free from contracture with intervention of apply contracture boot on left foot when in bed at night and remove when up in wheelchair in the am.R8's care plan, dated 07/31/19, with a target date of 08/14/25, states: Skin risk due to immobility with interventions to monitor skin and update medical provider with any concerns, assist with repositioning.R8's orders:03/02/24 Ensure tubi-grips from below knee to toes are present 24 hours per day (remove right tubi-grip at HS/replace at AM).04/23/25 PT to evaluate and treat. Special Instructions: For left foot brace.5/13/25 Apply contracture boot to left foot when in bed for the night and remove when up for the day.05/19/25 Consult to see Dermatology05/20/25 Apply sureprep to bilateral heels at AM and bedtime for further protection, also apply to blister on L lateral pinkie toe area. Twice A Day06/05/25 Mupirocin ointment: apply to blister left foot, 5th toe, per Dermatology twice a day.R8's most recent Braden assessment, dated 05/07/25, notes a score of 15 indicating R8 is at risk for PI.-Of note: No skin breakdown was documented at this time.R8's physical therapy notes:05/13/25 Mobility recommendations splinting/orthotics: Please put contracture boot on left foot when in bed and remove when up in wheelchair. Special instructions: check for reddened areas upon removal.-Of note: No daily skin assessment of left foot documented to assess for pressure injury related to contracture boot noted. 05/15/25 PTA provided R8 with a pommel w/c cushion to trial over the next few days with hopes of increased positioning with sitting upright in w/c and decreased pressure through left foot on foot board/pedals. Please see therapy with any questions or concerns.05/20/25 PTA observed a blister on patient's left foot at 5th metatarsal/phalangeal joint. Patient has been complaining of pain in this foot recently and therapy has been focusing on w/c positioning and use of orthotics. PTA informed nursing of blister; recommended and located podus boot for patient to wear on left foot when up in w/c 05/23/25 Discharge from PT due to highest

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure residents (R) with indwelling Foley catheters received care and treatment consistent with professional standards of practice to prevent complications or urinary tract infections from the catheter, for 1 of 1 resident (R7) reviewed with a Foley catheter. R7's Foley catheter was changed on a routine monthly basis without clinical indications and not following professional standards of practice. This is evidenced by:The Centers for Disease Control and Prevention (CDC), Healthcare Infection Control Practices Advisory Committee (HICPAC), Guideline for prevention of catheter-associated urinary tract infections 2009, read in part, E. Changing indwelling catheters or drainage bags at routine, fixed intervals is not recommended. Rather, it is suggested to change catheters and drainage bags based on clinical indications such as infection, obstruction, or when the closed system is compromised. Facility's policy titled, Catheter, Foley Insertion, with the reviewed/revised date of 01/2025, documented in part, The purpose of this procedure is to provide guidelines for the aseptic insertion of a urinary catheter. We do not routinely change catheters. We change them according to physician orders or as needed. R7 was admitted to the facility on [DATE] and current diagnoses included, in part, vascular dementia without behavioral disturbance, congestive heart failure, peripheral vascular disease, retention of urine, benign prostatic hyperplasia, rheumatoid arthritis, and cognitive communication deficit, Physician orders documented on 02/18/25, Change urinary catheter, 16 French,monthlyOnce A Day on Tue Every 4 Weeks. Record review did not identify physician rationale or clinical indications for the need to change the Foley catheter every 4 weeks. On 07/22/25 at 9:34 AM, Surveyor interviewed Director of Nursing (DON) B about the catheter changing policy. DON B stated the policy is to change as needed or as doctors order. Surveyor requested the physician's rationale for the need to change the Foley catheter monthly that follows clinical indications and professional standards of practice. DON B stated R7 has an appointment August 7th with urology, and this was the earliest appointment available. On 07/22/25 at 2:15 PM, DON B stated she does not have a physician rationale for changing R7's Foley catheter every four weeks.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to distribute food under sanitary conditions. This had the potential to affect all 35 residents. Observations revealed Food Service Worker (FSW) F serving and handling food on 2 of 3 days of survey with his facial hair cover under the level of his lips, allowing his moustache to remain uncovered.This is evidenced by: The facility policy titled Uniform Dress Code, dated last revised 01/24/25, states in part: Associates working with food .-Wear the approved hair restraint when on duty regardless of length or presence of hair.-Restrain all facial hair with a beard net/restraint.On 07/21/2025 at 12:15 PM, Surveyor observed FSW F in the main dining room kitchen area. FSW was plating food for multiple residents. As FSW F did this, he wore a facial hair cover under the level of his lips which allowed his moustache to remain uncovered. On 07/22/2025 at 9:00 AM, Surveyor observed FSW F go into the dining room kitchen area, retrieve food and take it to the main kitchen. As FSW F did this, he wore a facial hair covering under the level of his lips which allowed his moustache to remain uncovered. On 07/22/25 at 10:37 AM, Surveyor observed FSW F pushing food on a cart. As FSW F did this, he wore a facial hair covering under the level of his lips which allowed his moustache to remain uncovered. On 7/22/2025 at 1:20 PM, Surveyor's interview with FSW H revealed that dietary staff are to wear hair and beard nets while working with food.

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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, interview and record review, the facility did not maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 1 of 1 resident (R) (R5) observed.Facility did not place enhanced barrier precautions (EBP) for R5 who has an open wound. Facility staff did not wear appropriate Personal Protective Equipment (PPE) when providing wound care for R5. Activity Aide E was observed to perform ineffective hand hygiene. This is evidenced by: Example 1 Facility's policy titled Enhanced Barrier Precautions with reviewed date 01/08/25, documented 2.b. An order for enhanced barrier precautions (in accordance with physician-approved standing orders) will be initiated for residents with any of the following: i. Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers)…even if the resident is not known to be infected or colonized with a MDRO… R5 was admitted to the facility on [DATE]. R5's current diagnoses include in part, non-pressure chronic ulcer of left lower leg and long term use of anticoagulants. Review of R5's medical record documented on 05/06/25 an open wound on the left lower leg had developed. On 07/21/25 at 10:50 AM, Surveyor observed Registered Nurse (RN) G provide R5 wound care. RN G entered R5's room, sanitized hands and set up supplies. RN G placed a barrier under R5's left leg. RN G sanitized hands, applied gloves and proceeded with wound care. RN G did not wear a gown as part of PPE when providing care to R5. Surveyor observed the front of R5's left lower leg wound to be open with granulation tissue in the wound bed. Surveyor observed the outside of R5's door to have no signage for EBP. On 07/23/25 at 2:00 PM, Surveyor interviewed Director of Nursing (DON) B about EBP for R5's wound care. DON B indicated R5 should be on EBP for his wound. Surveyor reviewed with DON B R5 having no signage stating precautions are in place and observation of RN G not wearing appropriate PPE when completing wound care. Example 2 The facility policy, titled “Policy and Procedure on Hand Hygiene,” dated last reviewed 01/09/24, states in part: i. Dry thoroughly with a disposable paper towel and discard the towel immediately. j. Turn water off with a clean paper towel and discard the towel immediately. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/21/2025 at 11:36 AM, Surveyor observed Activity Aide (AA) E in the main dining room. AA E turned on the faucet, washed his hands, and then shut off the water faucet with his bare hands and dried his hands on the sides of his white t shirt. AA E then picked up a covered tray and carried it to the kitchen. On 07/23/2025 at 11:30 AM, Surveyor interviewed Director of Nursing (DON) B, who stated hands should be dried with a paper towel and a clean paper towel should be used to turn off the faucet when washing hands. DON B stated AA E is a younger staff who is great with the residents but just needs education in that area.