STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525692	A. Building B. Wing	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakwood Village East Health and Rehab Center	5833 American Parkway Madison, WI 53718

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 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)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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 residents received treatment and care in accordance with professional standards of practice for 1 of 3 residents (R1) reviewed for foley catheter (a thin, flexible tube inserted into the urethra to drain urine from the bladder) management.The facility manipulated and removed R1's foley catheter against physician orders.This is evidenced by:The facility's policy Change in a Resident's Condition or Status, dated 2/21, includes: Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status. The nurse will notify the resident's attending physician or physician on call when there has been a(an): need to alter the resident's medical treatment significantly.The facility's policy Acute Condition Changes - Clinical Protocol, dated 3/18, includes: The nursing staff will contact the physician based on the urgency of the situation. For emergencies, they will call or page the physician and request a prompt response (within approximately one-half hour or less). The attending physician (or a practitioner providing backup coverage) will respond in a timely manner to notification of problems or changes in condition or status. The nurse and physician will discuss and evaluate the situation. The physician will help identify and authorize appropriate treatments.The facility's policy Emergency and/or Alternative Physician Care, dated 4/13, includes: All residents shall be provided with emergency and/or alternative physician care. Should an emergency arise, and the resident's attending physician is not available, the emergency physician on-call must be contacted. The staff will follow designated protocols for evaluating and triaging medical symptoms and changes in condition and for gathering and reporting information to attending physicians and covering practitioners. The staff will use appropriate procedures to contact physicians, depending on arrangements and the urgency of a situation. If a physician and his/her backup coverage do not respond in a timely or appropriate manner to facility notification of medical issues, the nursing staff will contact the medical director for assistance. The facility's policy Indwelling (Foley) Catheter Removal, dated 8/22, includes: The purpose of this procedure is to provide guidelines for the approved method of removing an indwelling catheter. Verify that there is a physician's order for this procedure.R1 admitted to the facility on [DATE] with a foley catheter.R1's physician orders include DO NOT manipulate, flush, or exchange foley catheter, established with [Hospital] Urology, contact if any issues or questions. [Phone number provided], dated 9/3/25.R1's comprehensive care plan, printed 9/8/25, includes Do NOT PULL FOLEY OUT ONLY UROLOGY CAN DO THAT.R1's nurse progress notes include:9/3/25 3:34 PM . Do not manipulate, flush, or exchange foley catheter, contact [Hospital] Urology with any issues or questions.9/4/25 6:56 AM Progress Note Text: Monitor urine output every shift & document mL (milliliter) every shift Catheter not in place this AM, balloon felt close to the meatus and patient c/o (Complained of) pain. RN (Registered Nurse) found only 3mL in balloon [sic] on aspiration. Patient bed was soaking wet and appeared to have leaked around it all night. RN removed the catheter, notified NP (Nurse Practitioner) of the removal. Waiting for Urology clinic orders on re-insertion.9/4/25 10:48 AM Note Text: resident was sent out to [Hospital] ER (Emergency Room) to replace foley by urologist. Resident was accompanied by daughter. On 10/6/25 at 11:41 AM, Surveyor interviewed RN D (Registered Nurse) about R1's foley catheter. RN D indicated on 9/4/25 around 6:00 AM, she was made aware R1's foley catheter was not draining properly. RN D indicated R1's bed was wet with urine. RN D indicated she reviewed R1's medical record and was aware of the physician order to note manipulate, flush, or exchange foley catheter and to not pull foley out. RN D indicated she was aware urology needed to be notified of any issues with the foley catheter. RN D indicated she aspirated the foley catheter balloon and noted there was only 3mL of fluid in the balloon. RN D indicated she believed the catheter was not in the proper place in R1's bladder so she pulled the foley catheter out. RN D indicated she left a voicemail for R1's primary provider and attempted to call urology after she removed the catheter. RN D indicated she did not speak to a provider before or after the removal of the foley catheter.On 10/6/25 at 12:11 PM, Surveyor interviewed UCN E (Urology Clinical Nurse) regarding R1's foley catheter. UCN E indicated the clinic does have an afterhours number to contact a physician for urology concerns. UCN E indicated the facility should have left the catheter in place since the nurse would have been unable to determine placement. UCN E indicated the facility should have contacted a provider and should not have removed the catheter.On 10/6/25 at 1:41 PM, Surveyor interviewed DON B (Director of Nursing) regarding R1's foley catheter. Surveyor asked if removing fluid from the balloon would be considered manipulation of

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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 - Immediate jeopardy to resident health or safety 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 - Immediate jeopardy to resident health or safety 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 each resident receives care consistent with professional standards of practice (SOP), to prevent pressure injuries (PI) and each resident with PIs receives necessary treatment and services, consistent with professional SOP, to promote healing, prevent infection, and prevent new injuries from developing in 1 of 1 sampled residents (R2), out of a total sample of 3 residents reviewed.The facility inaccurately assessed R2's risk of skin breakdown.The facility failed to create a robust plan of care to prevent PI development.The facility failed to update R2's care plan timely with interventions to prevent worsening pressure injuries or prevent more injuries from developing.Staff inconsistently staged R2's wound and failed to describe characteristics of the wound bed in weekly assessments.R2's pressure injury presented with signs of deterioration and symptoms of infection. The facility failed to update R2's Medical Doctor (MD) timely with these changes.Staff did not give R2 risks and benefits when he refused to wear offloading boots for treatment of his pressure injuries.Staff did not follow standards of practice when performing wound care and treatment orders were not followed as prescribed by the physician.The facility's failure to provide care for R2, consistent with current SOP to prevent and treat PIs led to the development of multiple stage 3 or unstageable PIs and led to an infected stage 3 or unstageable PI. This created a finding of Immediate Jeopardy (IJ) that began on 8/31/25. NHA A (Nursing Home Administrator) was notified of the IJ on 10/8/25 at 2:15 PM. The immediate jeopardy was removed on 10/9/25. However, the deficient practice continues at a scope/severity of D (Potential for Harm/Isolated) as the facility continues to implement its action plan.Evidenced by:The American Medical Directors Association (AMDA) clinical practice guideline entitled, 'Pressure Ulcers and Other Wounds, dated 2017 states in part: .A pressure ulcer [Injury] is localized damage to the skin or underlying soft tissue, usually over a bony prominence or related to a medical or other device. The ulcer may present as intact skin or as an open ulcer and may be painful. The ulcer occurs as a result of intense or prolonged pressure or pressure in combination with shear.Recognition: Early recognition of pressure ulcers and of any risk associated with the development of pressure ulcers and other wounds is critical to their successful prevention and management .Assessment: The purpose of the assessment is to collect enough information to evaluate the patient's general condition, characterize a pressure ulcer; and identify related causes and complications.The National Pressure Ulcer Advisory Panel (NPUAP) at www.NPUAP.com defines PI's in the following categories:Category/Stage I: Non-blanchable erythemaIntact skin with non-blanchable redness of a localized area usually over a bony prominence.Category/Stage II: Partial thickness loss - Partial thickness loss of dermis presenting as a shallow open ulcer with a red, pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled or serosanguinous filled blister.Category/Stage III: Full thickness skin loss - Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscles are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. The depth of a Category/Stage III pressure ulcer varies by anatomical location.Category/Stage IV: Full thickness tissue loss - Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present. Often includes undermining and tunneling.Unstageable/Unclassified: Full thickness skin or tissue loss - depth unknown. Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar are removed to expose the base of the wound, the true depth cannot be determined; but it will be either a Category/Stage III or IV.Suspected Deep Tissue Injury (DTI) - depth unknown. Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid exposing additional layers of tissue even with optimal treatment.The facility's policy Pressure Ulcers/Skin Breakdown - Clinical Protocol, dated 4/18, includes: The nursing staff and practitioner will assess and document an individual's significant risk factors for developing pressure ulcers; for example, immobility, recent weight loss, and a history of pressure ulcer(s). The physician will order pertinent wound treatments, including pressure reduction surfaces, wound cleansing and debridement approaches, dressing (occlusive, absorptive, etc.), and