STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525701	A. Building B. Wing	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dove Healthcare - South Eau Claire	3656 Mall Drive Eau Claire, WI 54701

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 - 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** 47657 Based on observation, interview, and record review, the facility did not implement professional standards of practice to ensure that a resident does not develop pressure injuries (PIs), receives necessary treatment and services to promote healing of PIs, or prevent new PIs from developing or worsening for 1 of 3 residents (R) (R245) sampled for PIs. R245 was admitted to the facility with a stage 1 PI and was determined to be at high risk for PIs. A turning and repositioning program was not implemented, monitored, or reviewed, education on risk vs benefits of repositioning and offloading to prevent/improve PIs was not completed, and an air mattress was not placed timely. R245's PI worsened to an unstageable PI. This example is being cited at actual harm. This is evidenced by: National Pressure Injury Advisory Panel (NPIAP) guidance recommends repositioning all individuals with or at risk of pressure injuries on an individualized schedule, unless contraindicated. Determine repositioning frequency with consideration to the individual's level of activity and ability to independently reposition. Reposition the individual in such a way that optimal offloading of all bony prominences and maximum redistribution of pressure is achieved. The facility policy titled: Pressure Injury Prevention and Management last reviewed September 2024 states: This facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries. The facility policy further describes: Avoidable means that the resident developed a pressure ulcer/injury, and that the facility did not do one or more of the following: evaluate the resident's clinical condition and risk factors: define and implement interventions that are consistent with resident needs, resident goals, and professional standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate. R245 was admitted to the facility on [DATE] with diagnoses of displaced fracture of base of neck of right femur and chronic kidney disease. R245's Minimum Data Set (MDS) assessment, dated 04/14/25, was currently in process at time of survey and identified R245 scored 11/15 during a Brief Interview for Mental Status. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 04/08/25, the facility entered a progress note stating in part . Nurse to Nurse report documentation from Hospital indicates Skin Alterations/Open Area: Pinkness/redness to buttock - zinc and foam dressing every 3 days. On 04/08/2025, the facility entered a skin note: Inner gluteal cleft Blanchable pinkness. On 04/8/2025, the facility completed a Braden Scale for Predicting Pressure Ulcer Risk. Braden Evaluation: Result: At Risk Score: 15.0. A Braden Scale score of 15 indicates a mild risk for developing pressure injuries. On 04/08/25, an individualized care plan was initiated for R245 with a target date of 07/07/25 stating: Risk for skin breakdown related to history of falls, cognitive impairment, decreased mobility after fracture and fall, with a goal of My skin will be kept clean and dry. The care plan had no specific interventions for pressure injury prevention. On 04/10/25, the facility entered a Wound/Skin Healing Note: Weekly wound tracker completed for resident. Wound Information: Coccyx - Pressure: Length = 0.7, Width = 1.0, Depth = 0.1, - Stage Unstageable. This is the first time writer has observed the wound. On 04/10/2025, the facility completed another Braden Scale for Predicting Pressure Ulcer Risk Braden Evaluation: Result: At Risk Score: 17.0. A Braden scale score of 17 indicates a moderate risk for developing pressure ulcers. This means the person is at a level where careful monitoring and preventive measures are necessary to minimize the risk of developing pressure injuries. On 04/10/25, the facility revised R245's care plan to: The resident's Pressure ulcer will show signs of healing and remain free from infection by/through review date. And added interventions of: Administer treatments as ordered and monitor for effectiveness. Educate the resident/family/caregivers as to causes of skin breakdown; including transfer/positioning requirements; importance of taking care during ambulating/mobility, good nutrition and frequent repositioning. Of note: the facility was unable to provide documentation to support education was completed. The resident needs assistance to turn/reposition at least every 2 hours, more often as needed or requested. Use pillows to off-load side to side. On 4/11/2025, the facility entered a Nutritional at Risk (NAR) Note Text: NAR meeting held on this day. Residents skin is not intact at this time. Sacrum - Resident has a small unstageable pressure injury to his sacrum area. On 04/15/25, the facility updated R245's care plan to include a pressure relief cushion to recliner and wheelchair. On 04/16/25 at 7:01 AM, Surveyor began continuous observation of R245 who was positioned on buttocks with head of bed elevated awaiting breakfast and noted the following: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Conducted continuous observation of R245 lying on back with head of bed elevated awaiting breakfast. Of note: No pillows used to off load per care plan. -8:15 AM, Surveyor observed Registered Nurse (RN) C enter R245's room to inform of plan to complete wound treatment after resident was completed with breakfast. -8:24 AM, Surveyor observed R245's call light and staff removed breakfast tray. No direction provided to reposition. R245 remained sitting on backside with HOB elevated. -8:33 AM, Surveyor observed RN C conduct wound care. Upon removing dressing, RN C noted R245's entire buttocks were reddened. RN C stated, Probably from being on buttocks, and pointed out scarred tissue from a past history of open areas. RN C stated last seeing wound on 04/11/25 and stated wound was unstageable and currently measures 0.3 cm x 0.5: Eschar 50% slough/50% granulation. RN C confirmed that area was not open upon admission on 04/08/25 and opened about 2 days later. -8:36 AM, upon completion of wound treatment, Surveyor asked RN C what interventions were in place to prevent further skin break down. RN C stated that on 04/15/25 an offer of an air mattress was declined by R245 and was hoping to talk to spouse who may be able to convince R245 to allow an air mattress. RN C also indicated that R245 has a gel cushion in recliner and wheelchair and is on a positioning program to reposition side to side. Of note, Surveyor requested evidence of conversation with R245 regarding declination of an air mattress as facility was unable to provide. -8:53 AM, Surveyor continued constant observation and observed Certified Nursing Assistant (CNA) D complete R245's morning cares. Surveyor observed heels not floated off of mattress. Surveyor asked CNA D what skin breakdown interventions R245 has on care plan. CNA D stated, [R245] is repositioned every 2 hours when in bed, has a cushion on recliner and wheelchair and should have had heels floated last night. CNA D stated heels are intact and a little red. -9:04 AM, Surveyor observed CNA D assist R245 to transfer to recliner and position on buttocks. Of note: No pillows used to off load per care plan. -10:28 AM, Surveyor observed R245 continue to sit in recliner on buttock. -11:03 AM, R245 placed on call light requesting assistance with urinal. CNA D assisted R245 while resident remained sitting on buttocks. CNA D lowered pants and positioned urinal for R245. Upon completion, CNA D did not offer/encourage repositioning to off load. -12:10 PM, Surveyor observed staff administer R245's medication and lunch tray while R245 remained seated in recliner. No repositioning/offloading offered. On 04/16/25 at 1:17 PM, Surveyor ended continuous observation as R245 was taken to therapy. Of note, R245 was not offloaded/repositioned off of PI on 04/16/25 from 9:04 AM until 1:17 PM (4 hours and 13 minutes). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 04/17/25 at 8:31 AM, Surveyor interviewed R245 who stated usually stays in recliner or wheelchair during day and doesn't believe staff reposition off buttocks. R245 stated that when in bed staff at times do place a pillow behind his back but can tell is still lying on buttocks. On 04/17/25 at 10:14 AM, Surveyor interviewed RN E regarding R245's intervention in place to prevent PI. RN E stated was not aware of what interventions were in place besides every 2-hour repositioning and has no knowledge of whether R245 is repositioned off of PI when in bed. On 04/17/25 at 10:22 AM, Surveyor interviewed CNA D who stated CNA D has never seen R245 on side in bed upon coming on day shift duty. CNA D stated he was talking to RN C of ideas of what to do when R245 prefers to sit in recliner most of the day and was directed to attempt to offload him as much as possible on side in recliner. Surveyor asked if R245 is offered repositioning, CNA D stated R245 has never went back to bed after getting up in recliner for the day. CNA D stated R245's care plan states to reposition every 2 hours and we try to offer. Surveyor shared observations of no repositioning/offloading for any length of time on 04/16/25 from 7:01 AM to 1:17 PM. CNA D indicated R245 likes the recliner and often will turn slightly on left side and curl legs up off PI area. On 04/17/25 at 10:35 AM, Surveyor observed RN F and CNA D have R245 position self on left side and curl up legs. RN F placed palm of hand under R245's buttocks and indicated that R245 was sitting slightly off PI, but still had some pressure applied to PI. On 04/17/25 at 10:51 AM, Surveyor interviewed RN C who reiterated that R245's buttocks were reddened during dressing change on 04/16/25 and appeared to have a past history of skin breakdown. RN C notified Surveyor the air mattress was placed on R245's bed this AM. Surveyor asked what type of mattress was on R245's bed prior to air mattress being applied. RN C stated the previous mattress was just a regular facility mattress. Surveyor requested information regarding appropriate use of current recliner and wheelchair cushions based on R245's current unstageable wound. RN C indicated that recliner cushion was an Equacel cushion, was not sure what rating it is for and will check. RN C stated the wheelchair cushion was just a regular cushion Of note, the facility was unable to provide evidence to support the current PI relief cushions used were appropriate for an unstageable PI.