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	0019130	A. BUILDING: _____ B. WING _____	C 10/29/2025

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N 000	Initial Comments On 10/29/2025, Surveyor conducted 3 complaint investigations at Ripon Copperleaf AL Operations LLC, a CBRF in Ripon. One deficiency was identified. Three complaints were substantiated. Census: 31	N 000		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on interview and record review, the provider did not update Resident 1's individual service plan (ISP) based on assessment when their condition or needs changed. Resident 1 had a history of pressure and diabetic wounds. The provider did not ensure Resident 1's ISP was updated based on assessment during changes in condition to identify interventions to	N 389		

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

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N 389	Continued From page 1 manage wound cares. Findings include: The Department received three complaints alleging the provider was not providing appropriate care to their residents. On 10/29/2025 at approximately 9:30 AM, Surveyor reviewed portions of Resident 1's record. Resident 1 was admitted to the facility on 02/12/2025 with diagnosis including: encounter for orthopedic aftercare following surgical amputation, Type II Diabetes, Peripheral vascular diseases, spinal stenosis, quadriplegia, diabetic ulcer of right heel, multiple diabetic toe wounds, coccyx pressure ulcer Stage III, indwelling catheter and right posterior and lower leg blisters (reoccurring). The most recent ISP was signed and dated 02/11/2025 and indicated the following: Resident has an ADL self-care performance deficit ...Skin Inspection: when assisting the resident, observe the skin for any redness, open areas, scratches, cuts, tears, bruises/discolorations and report any changes to the nurse ...The resident has diabetic ulcer of the right heal, along with small blister on toe, with goals indicating the resident will have no complications related to ulcer through review date. Interventions indicated observe pressure areas for color, sensation, temperature. Report changes to the nurse..wound/dressing: right heel, observe dressing. Change dressing and record observations of site ...The resident has potential/actual impairment to skin integrity of the groin and blister on the right heel and toe, buttocks and right calf with goal indicating the resident will maintain clean and intact ski with interventions indicating Asension at Home	N 389		

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N 389	Continued From page 2 (Outside Provider who provides in home wound care) following heel and buttocks as well as resident goes to (healthcare clinic) ...for resident right heel and right posterior and lower leg please see treatment orders, and review service plan ...Observe skin. Keep skin clean and dry ...Report any skin alterations to nurse. On 10/29/2025 at approximately 1:00 PM, Surveyor continued with medical record review, reviewing Resident 1's treatment record and orders and noted the following: Mepilex 4x4 dressing- Apply to left thigh once weekly on Thursday, left thigh near knee/prosthetic, order date 02/11/2025 indicated completing every AM, and PRN. Cleanse wound with vashe or saline, apply saline moistened promogran and mb to right heal, right posterior lower leg, right 4th toe. Change three times weekly plus PRN as needed for wound on right lower leg and heal. Order dated 08/15/2025. Cleanse wound with vashe or saline, apply saline moistened promogran and mb to right heal, right posterior lower leg, right 4th toe. Change three times weekly plus PRN one time a day every Monday, Wednesday, Friday. (Home Health Care Agency) will do his/her wound care. Order date 08/15/2025. On 10/29/25 at 11:00 AM, Surveyor reviewed Resident 1's medical record and noted (healthcare clinic) outpatient wound care notes indicated the following: 08/26/2025- Wounds debrided today, coccyx wound healed, continue same treatment for toe, heel and leg wounds. After care note dated 10/14/2025, while Resident	N 389		

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N 389	Continued From page 3 1 was admitted to the hospital following neck surgery, Resident 1 was evaluated by (healthcare clinic) Wound Care due to observation of multiple wounds upon admission. Provider consult note indicated the following regarding wounds: Coccyx and bilateral buttocks (clustered)-stage III pressure injury. Pink tissue, no slough, no exposed structures, moist with scant drainage. Peri wound red, dry and blanchable. Measurements indicated 5cm x 5cm with wound depth of .1cm. Left anterior thigh-deroofed blister. Intact fluid filled blister that deroofed, oozing serous fluid, now all clean pink tissue. Peri wound pink. No induration, fluctuance, erythema, edema, or crepitus noted. Number of wounds indicated was three. Largest wound measured at 2.8cm x 4.7 cm with wound depth of .1 cm. Orders indicated to be determined for deroofed blister. Primary dressing: foam with border. Change dressing three times weekly and as needed. Right posterior leg-wound Right heel-unstageable pressure injury Consultation note further indicated Resident 1 is followed by (healthcare clinic) Wound Care outpatient for treatment of right posterior lower leg wound as well as right heel. The right heel wound being present for 9 months and the right posterior leg with etiology unknown, looking significantly improved. Consultation was conducted due to bandage changes on buttock and coccyx with date of 9/24/25. Surveyor further noted in Resident 1's medical record Resident 1 was seen weekly by	N 389		

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(healthcare clinic) outpatient wound care as well as (Home Health Agency) for wound and catheter cares upon admission to the facility on 02/12/2025 through 08/20/2025. Surveyor further noted Resident 1 was seen by (a different Home Health Agency) from 08/28/2025 through 10/10/2025 when Resident 1 was admitted to the hospital for scheduled surgery and discharged from the facility.

On 10/29/2025 at approximately 9:50 AM, Surveyor reviewed Resident 1's medical record and noted the following weekly skin assessments:
6/12/25- small sore inner thigh (rear of thigh)
6/19/25-coccyx dime sized open area cleansed area and applied barrier cream. Groin, small water blisters.
6/27/25- Groin has blisters some have bandages some are not bandaged. There is about four of them. Coccyx open area on buttocks has bandages, washed and creamed.
7/9/25- Right buttocks open area has bandages, washed and creamed.
7/16/25- No skin concerns noted.
7/21/25- Left thigh round red mark on inside of left thigh near scrotum.
7/28/25- No skin concerns noted.
8/6/25- No skin concerns noted.
8/14/25- No skin concerns noted.
8/28/25- Right iliac crest (front) bruise, abdomen scrabs from scratching.
8/31/25- Coccyx open source washed and creamed and bandaged.
9/7/25- Right heel, Right calf, Right toe 4th followed by ascension and Theda Care.
9/15/25- Blister left thigh, open sore on buttocks, sacrum patches followed by Accession. Wound on right heal and calf following wound orders from Theda Care.
9/21/25- Right hip open, cuts, red and clear

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oozing. Upper mid back multiple scratches, dried blood some open.
9/30/25- Right hip, blisters on outside of left thigh.
10/8/25- Noted no change to areas with blisters.

Surveyor noted during the forementioned review of Resident 1's ISP did not contain goals and interventions regarding all of Resident 1's skin integrity concerns. Surveyor noted Resident 1's ISP did not contain interventions to provide care and preventative measures for Resident 1's multiple, reoccurring thigh blisters as well as Resident 1's Stage III coccyx pressure injury.

On 10/29/2025 at 8:55 AM, Surveyor interviewed Caregiver-C who indicated working with Resident 1 and completing cares on upper thigh blisters. Caregiver-C verified Resident 1 required full assist with the use of a Hoyer Lift, repositioning and wound and catheter cares. Caregiver-C indicated Resident 1 would sometimes be resistive to repositioning, further indicating at times Resident 1 did not like to go from wheelchair to bed or be repositioned on sides. Caregiver-C indicated cleaning wounds and bandaging the wounds as well as retaping the catheter tubing and securing to Resident 1's inner thigh area. Caregiver-C indicated Resident 1 had heal wound, and multiple toe wounds and did not complete cares on coccyx wound. Caregiver-C further indicated the process after completing wound cares was to bandage and date the bandage when changed PRN, as Resident 1 had Home Health and outpatient care to wounds.

On 10/29/2025 at 10:33 AM, Surveyor interviewed Registered Nurse (RN)-F from (Home Health agency) who indicated Resident 1 received home health services for catheter and wound cares from 2/12/25 to 8/20/25. RN-F

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N 389	Continued From page 6 indicated wounds that home health was providing wound care for were right heal, right posterior lower leg and right digits. RN-F verified that coccyx wound was not being cared for by (Home Health agency) and RN-F had no record of coccyx wound for Resident 1. RN-F indicated that home health relies on the facility staff, as well as assessments to indicate new wounds, or previously healed open areas reopening. On 10/29/2025 at 12:02 PM, Surveyor interviewed Caregiver-D who indicated frequently providing cares to Resident 1. Caregiver-D further indicated that Resident 1 was not resistive to cares, and would sometimes refuse repositioning for certain caregivers, but not for Caregiver-D, further explaining Resident 1 would spend much of the day in his/her wheelchair, per Resident 1's choice. Caregiver-D further indicated that Resident 1 received full assistance with all cares, had multiple wounds and was followed by Home Health agencies for wound cares. Caregiver-D further indicated Resident 1 had open wounds to buttocks, lower leg, heal and toes. Caregiver-D further indicated multiple blisters on Resident 1's upper thigh/groin area. Caregiver-D indicated that Resident 1 would have bowel movements daily, requiring Caregiver-D to clean buttocks and wound, replacing bandage to coccyx daily, further indicating Caregiver-D did not date bandages once replacing the bandage. Caregiver-D further indicated that Resident 1's thigh blisters were bandaged and cleaned, further indicating on one occasion home health agency bandaged a blister with adhesive being over the closed blister. Caregiver-D confirmed staff follow Resident 1's ISP for wound care orders, further indicating that Resident 1's ISP did not identify the exact care that should be provided for all of Resident 1's skin concerns.	N 389		

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N 389	Continued From page 7 On 10/29/2025 at 12:06 PM, Surveyor interviewed (other home health agency's) Executive Director (ED)-E who indicated Resident 1 was enrolled in services for wound care and catheter care from 08/28/2025 until Resident 1 was discharged due to a planned surgery and subsequent skilled nursing rehabilitation stay following surgery on 10/13/2025. ED-E verified Resident 1 was receiving wound services for right heal wound and leg wounds. ED-E indicated no record of coccyx wound. ED-E indicated that home health relies on the facility staff, as well as assessments to indicate new wounds, or previously healed open areas reopening. On 10/29/2025 at 2:13 PM, Surveyor interviewed Assisted Living Manager (ALM)-A and Director of Wellness (DW)-B. DW-B indicated Resident 1 was admitted to the facility with heal and calf wounds and wound care treatment and orders being provided and managed by home health agencies and outpatient wound care clinic. DW-B indicated Resident 1 had a history of coccyx wound that was closed and not open at the time of admission, confirming that the coccyx wound did briefly reopen during the time Resident 1 resided at the facility, but had closed since May of 2025. DW-B and ALM-A both confirmed that Resident 1 had recurring blisters on upper right thigh. ALM-A indicated the right thigh blisters were located where the catheter strap was placed for Resident 1. ALM-A knew of one right thigh wound that was approximately 1 inch in diameter. ALM-A and DW-B further indicated no knowledge of blisters for Resident 1 on left thigh, or open areas to buttocks or coccyx. DW-B indicated interventions for coccyx wound were added to Resident 1's ISP in March of 2025 and updated in August to reflect both the Home	N 389		

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Health Agencies and outpatient orders for wound care. At this time, DW-B indicated that wound care notes are not "great" and confirmed that Resident 1's ISP was not updated to identify new blisters on the left inner thigh and did not identify specific interventions associated with those new blisters or the skin concerns on the buttocks/coccyx, further confirming that the ISP indicated that home health and outpatient were responsible for buttock/coccyx wounds, despite confirming that the facility was responsible for those wounds, and staff were caring for these wounds without specific instructions. DW-B confirmed that staff were inconsistent with caring for wounds, and the documentation of wound care, as well as with new wounds being observed, documentation on weekly skin checks of not only new wounds but documenting those existing wounds was not being conducted appropriately. DW-B indicated at that time that training has been provided to staff regarding change of condition, providing training documentation to Surveyor. DW-B at that time indicated retraining and updating ISPs to include specific instructions on reporting and care of wounds will need to be implemented to ensure wound care is provided for all wounds and all skin conditions are reported timely. DW-B further indicated acknowledgement that there was not clear documentation of where the wounds were, further acknowledging the lack of documentation could present barriers with monitoring and reporting changes in wounds and the concern with unlicensed staff connecting treatment orders and Resident 1's ISP with the importance of specificity in the ISP to identify the resident's needs and interventions. ALM-A indicated with regards to Resident 1's ISP and prevention of wounds that Resident 1 did spend most of the day in wheelchair per Resident 1's choice and

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N 389	Continued From page 9 would after reengagement reposition. ALM-A indicated that repositioning was a line of defense to aide in ensuring that pressure was relieved off of Resident 1's bottom as Resident 1 did have history of pressure injury to the area. ALM-A confirmed that repositioning and interventions to prevent pressure ulcers was not included in Resident 1's ISP. On 10/29/2025 at approximately 2:45 PM, Surveyor confirmed training provided through reviewing training documents provided by ALM-A and DW-B that caregiving staff are directed to report any change of condition in skin conditions of any new wounds/rashes, report any area where there is redness, report any area where there is persistent moisture, any changes in sensation, tingling or discomfort. Any new skin conditions on 24-hour report, report skin that is boggy or mushy or softer to touch, abrasions, lacerations, blisters, calluses, corns, burns, itching, jaundice, puncture wounds, skin tears, splinter or the appearance of infections, red, draining swelling or warm to touch to facility nurse or administration.	N 389		