STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020660	A. BUILDING: _____ B. WING _____	C 07/18/2025

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SUN VALLEY LUXEMBURG	143 SCHOOL CREEK TRAIL LUXEMBURG, WI 54217

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N 000	Initial Comments On 07/16/2025 with additional information gathered through 07/18/2025, Surveyor conducted a complaint investigation at Sun Valley Luxemburg. As a result, 1 deficiency was identified and the complaint was substantiated. Census: 17	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 record review and interview, the provider did not ensure 1 of 1 resident (Resident 1) had their individual service plan (ISP) updated when there was a change of condition. Between 03/09/2025 and 04/28/2025, the provider did not update Resident 1's ISP after s/he experienced a change in condition related to skin integrity. Findings include:	N 389		

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

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N 389	Continued From page 1 On 06/18/2025, the Department received a complaint alleging residents' care needs were not being met. On 07/16/2025, Surveyor conducted a complaint investigation. Surveyor requested Resident 1's closed record from House Manager (HM) A to include his/her signed ISP, face sheet, observation notes, medication administration record (MAR), active cares, vital history, hospice notes and physician orders. On 07/16/2025 at approximately 11:00 AM, Surveyor reviewed Resident 1's closed record and noted the following: Resident 1 admitted to the facility on 08/01/2017 with diagnoses to include congestive heart failure and had an activated power of attorney (POA) and managed care organization. Resident 1 admitted to hospice care on 03/12/2025 and passed away on 05/23/2025. Resident 1's signed ISP, dated 02/24/2025, reflected under "Skin Care ...Resident's skin is in good condition with no open wounds, able to monitor skin and apply lotions independently ...Maintain skin integrity." The "Active Cares" document included care tasks dating back to 08/08/2024 and under "Skin Care" with a scheduled date of 08/08/2024 notes, "Resident's skin is in good condition with no open wounds, able to monitor skin and apply lotions independently." A task of "Repositioning" was added 03/11/2025 and notes, "Staff are to reposition resident every two hours to offload weight on [his/her] back side. Use a pillow behind [his/her] back when [s/he] is on [his/her] side if	N 389		

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needed to assist in offloading." (Surveyor note: Another Active Care titled "Hospice Resident - Eating Monitoring" was added as of 03/21/2025. Resident 1 admitted to hospice on 03/12/2025 and there was no additional documentation reflecting this prior to 03/21/2025.)

Observation notes from 03/01/2025 to 05/23/2025 read in part:

-- 03/09/2025, Observation Note, 5:30 AM, "Resident has some spots on [his/her] bottom which looks to maybe could [sic] be the start of a pressure sore." Author: Caregiver C.

-- 03/11/2025, Observation Note, 11:15 AM, "Looked at resident's bottom [sic] resident appears to [sic] a lot of red circle marks on [his/her] bottom [sic] they're not open at this time it looks like its form [sic] sitting on [his/her] bottom all the time. Encouraged resident to lay down and get off bottom. Also talked to [Nurse D] [s/he] updated care plan to repositioning every 2 hours." Author: HM A.

-- 03/11/2025, Observation Note, 12:00 PM, "...RN (registered nurse) updated PCP (primary care provider) regarding reddened areas on resident's buttocks. RN requested an order for a barrier cream ..." Author: Nurse D.

-- 03/12/2025, Observation Note, 1:00 PM, "Resident signed onto [Hospice E] today. A hospital bed will be delivered at some point today." Author: HM A.

-- 04/28/2025, Observation Note, 10:00 AM, "Was helping clean resident up after a bowl [sic] movement and noticed a sore starting on [his/her] butt, cleaned the area and put fresh brief on and

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advised management. Advised to put a pillow under a hip/butt and rotate to the other side every 2 hours while in [his/her] chair, wheelchair, and in bed to help prevent worsening and getting more ..." Author: Caregiver E. (Surveyor note: There is no documentation to reflect hospice was notified of the start of Resident 1's pressure sore.)

-- 04/29/2025, Hospice Note, 10:15 AM, "Patient found sleeping in wheelchair comfortably. Easily aroused, disposition cheerful, patient orientated to self and situation - not time or place. Edema bilateral pedal noted R plus 2, L plus 3 with trace noted in both hands. Vitals within normal limits for patient's baseline ... Patient stated [his/her] left arm was getting better and had complaints of pain at this time. Patient requested light changes and to be placed in bed for a nap. Patient transferred using pivot ...[sic]." (Surveyor note: There is no documentation to reflect hospice was notified, observed and/or assessed Resident 1's pressure sore.)

-- 05/08/2025, Observation Note, 5:45 AM, " ...Resident's bottom is also looking sore and seems to be developing a pressure sore, a barrier was applied." Author: Caregiver C.

-- 05/12/2025, Observation Note, 8:30 PM, "[Caregiver F and Caregiver G] went into resident's room to complete nightly cares and noticed a scab like piece on resident's bottom. When looking closely [Caregiver F and Caregiver G] found a golf ball sized open pressure wound on top of resident's buttocks. Administrator and hospice was notified. Hospice called back and stated a nurse will be out tomorrow to assess and bandage wound. Please keep area clean." Author: Caregiver G.

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N 389	Continued From page 4 -- 05/13/2025, Observation Note, 8:45 AM, "Resident has a golf sized open pressure wound on top half of resident's buttocks. Please lay resident down in bed to get [him/her] off [his/her] buttocks in between meals and activities." Author: HM A. -- 05/13/2025, Hospice Note, 2:15 PM, "Routine hospice RN visit: Patient has new stage 3 pressure injury on right buttocks. Hospice nurse will be doing wound care Monday, Wednesday, and Friday. Please ensure that patient is relieving pressure on buttocks. Try of [sic] have patient get in bed after meals and use pillows for positioning. Hospice ordered alternating pressure mattress and gel cushion for wheelchair ..." -- 05/18/2025, Observation Note, 5:45 AM, "[Caregiver C] was getting resident up this morning and as [s/he] stood to sit on the toilet [his/her] packing fell out. The packing was completely saturated with brown fluid and was dripping from [his/her] wound. [Caregiver C] asked resident if [s/he] was having any pain but only said pain in [his/her] rib area and nothing about pain in [his/her] bottom from the pressure sore. A call is out to [Hospice E] waiting on them to return call." Author: Caregiver C. -- 05/18/2025, Observation Note, 11:15 AM, "[Hospice E] came this morning to repack resident wound. Resident says no pain and is doing good." Author: Caregiver H. -- 05/19/2025, Hospice Note, 12:15 PM, " ...Arrived to find patient sitting in bed. Noted strong odor from wound. Wound care completed to PI [sic] on buttocks. Noted patient to be fidgeting during wound care, asked if [s/he] was having pain and [s/he] said [s/he] was on [his/her]	N 389		

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N 389	Continued From page 5 buttocks. Patient previously has been reporting no pain to wound. Patient may need to be premeditated [sic] prior to wound care if pain to wound continues to worsen. Patient needs to continue to be paid [sic] down in bed between meals to relieve pressure on buttocks. Sit to stand lift was delivered to facility over weekend. Please use sit to stand for safe transfers as patient is becoming more weak ..." -- 05/21/2025, Hospice Note, 3:00 PM, " ...Patient experiencing pain with repositioning and wound care. Please administer pain medication prior to repositioning patient. Patient needs to be repositioned at least every 2 hours, and not spend more than 2 hours in [his/her] wheelchair at a time ...Noted the start of new unstageable pressure injury to left heel. Please have patient wear heel protector boots while in bed." Review of Resident 1's Medication Administration Record (MAR) from March 2025 reflects Resident 1 was administered Calmoseptine Ointment, a barrier cream, at 2:00 PM and 8:00 PM on 03/12/2025. The instructions were to "apply topically to affected area 3 times daily." The only date the ointment was administered was on 03/12/2025. A document titled, "Assessment (Revised) Change in Condition" completed on 05/21/2025 notes, "Resident is a Hoyer lift now. Resident has a big/deep Kennedy sore on the [genital] area, there are also new sores/openings starting in the same area." The document also reflects Resident 1 is on hospice services and they are providing daily wound care as well as bathing assistance. Additionally, the assessment reflects Resident 1 requires staff assistance with transfers, dressing, grooming, toileting and eating.	N 389		

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N 389	Continued From page 6 On 07/16/2025 at 10:25 AM, Surveyor interviewed Nurse I who reported Resident 1 admitted to hospice services on 03/12/2025 until his/her passing on 05/23/2025. Nurse I reported they were seeing Resident 1 daily for about a week before s/he passed away as s/he had a wound on his/her bottom and they were providing wound care services. Nurse I indicated Resident 1's wound was on his/her right buttock near his/her coccyx. Nurse I reported the wound was "very large, it came on very fast and it opened up. It looked like a possible Kennedy ulcer." During an interview with HM A and Administrator (ADM) B on 07/16/2025 at 12:35 PM, they stated Resident 1's active cares was updated on 03/11/2025 to reflect repositioning every 2 hours when they first noticed the reddened area on his/her buttocks. In addition, they stated they previously updated active cares on 02/27/2025 when Resident 1 was placed on a 2-hour toileting schedule. During an interview with Director of Care Services J on 07/18/2025 at 12:30 PM, s/he confirmed they were not aware of any skin integrity concerns until 05/12/2025 when they were first notified by the facility of Resident 1's pressure sore on his/her buttocks. Director of Care Services J stated s/he reviewed their documentation and did not see any nursing notes regarding any reported wound concerns by the facility on 04/28/2025. On 07/18/2025 at 10:10 AM, Surveyor interviewed HM A and Administrator (ADM) B. HM A confirmed the barrier cream was administered on 03/12/2025, but was discontinued and a bedside order was requested. HM A reported s/he	N 389		

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N 389	Continued From page 7 could not recall if the bedside order was received as this was around the time Resident 1 admitted to hospice and they may have had a standing order to include a barrier cream. Surveyor inquired if they use hospice's plan of care or their own ISP and ADM B reported, "It's usually a combined effort and this should have happened. There are a few areas of learning." HM A confirmed s/he did not have a plan of care from hospice, so they were using their own ISP. HM A acknowledged Resident 1's ISP was not updated when s/he experienced a change in condition related to skin integrity.	N 389		