

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0018908	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 07/16/2026
NAME OF PROVIDER OR SUPPLIER MARTHAS II CBRF		STREET ADDRESS, CITY, STATE, ZIP CODE 404 W WATER ST PRINCETON, WI 54968		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y3244	Continued From page 1 provider did not ensure Resident 2 received adequate and appropriate care within the capacity of the facility. Resident 2 was at risk for the development of pressure injuries and developed an open wound to his/her right buttock (gluteal) on 03/06/2026. Physician orders were received on 03/06/2026 for wound care and dressing changes and a referral to the wound clinic. Documentation revealed wound care and dressing changes were not performed as ordered and a referral to the wound clinic was not facilitated until 03/20/2026, resulting in a 14-day delay in specialized care. Additionally, the provider made no change to Resident 2's plan of care to promote healing, prevent infection and avoid new pressure injuries from developing. On 03/26/2026, Resident 2 was sent to the ED (Emergency Department) and admitted to the hospital with an infected, unstageable pressure injury to the right buttock and additional pressure injuries to the left buttock and right heel. Findings include: The NPUAP (National Pressure Injury Advisory Panel) published a Third Edition in 2019, entitled "Prevention and Treatment of Pressure Ulcers/Injuries: Quick Reference Guide," which indicated the following: ~ Category/Stage 4: Full thickness tissue Loss- Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling. The depth of a Category/Stage IV pressure ulcer varies by anatomical location ...Category Stage IV ulcers can extend into the muscle and/or supporting	Y3244		

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Y3244	Continued From page 2 structures (e.g., fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable. ~ Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss in which the extent of tissue damage with the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. ~Risk Factors and Risk Assessment: Consider individuals with limited mobility, limited activity and a high potential for friction and shear to be at risk of pressure injuries. Consider individuals with a Category/Stage I pressure injury to be at risk of developing a Category/Stage II or greater pressure injury. Consider the potential impact of an existing pressure injury of any Category/Stage on development of additional pressure injuries. Consider the potential impact of a previous pressure injury development. Consider the impact of perfusion and circulation deficits on the risk of pressure injuries. Consider the impact of oxygenation deficits on the risk of pressure injuries. Consider the impact of impaired nutritional status on the risk of pressure injuries. Consider the potential impact of moist skin on the risk of pressure injuries...Consider the potential impact of older age on the risk of pressure injuries. Consider the potential impact of general and mental health status on pressure injury risk...Develop and implement a risk-based prevention plan for individuals identified as being at risk of developing pressure injuries... ~ Preventive Skin Care: Implement a skin care regimen that includes: Keeping the skin clean and appropriately hydrated, cleansing the skin promptly after episodes of incontinence, and	Y3244			

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Y3244	Continued From page 3 protecting the skin from moisture with a barrier product. ~Nutrition Assessment and Treatment: Conduct nutritional screening for individuals at risk of a pressure injury. Conduct a comprehensive nutrition assessment for adults at risk of pressure injury who are screened to be at risk of malnutrition and for all adults with a pressure injury. Develop and implement an individualized care plan for individuals with, or at risk of, a pressure injury who are malnourished or who are at risk of malnourished or who are at risk of malnutrition. Provide 1.2 to 1.5 g protein/kg body weight per day for adults with a pressure injury who are malnourished or at risk of malnutrition. ~Repositioning and Early Mobilization: Reposition all individuals with or at risk of pressure injuries on an individualized schedule. Reposition the individual in such a way that optimal offloading of all bony prominences and maximum redistribution of pressure is achieved. Reposition the individual to relieve or redistribute pressure using manual handling techniques and equipment that reduce friction and shear. ~Support Surfaces: Select a support surface that meets the individual's need for pressure redistribution based on the following factors: level of immobility and inactivity, need to influence microclimate control and shear reduction, size and weight of the individual, number, severity and location of existing pressure injuries, risk for developing new pressure injuries...Assess the relative benefits of using an alternating pressure air mattress or overlay for individuals at risk of pressure injuries...Select a seat and seating support surface that meets the individual's need for pressure redistribution...Use a pressure	Y3244			

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Y3244	Continued From page 4 redistribution cushion for preventing pressure injuries in people at high risk who are seated in a chair/wheelchair for prolonged periods, particularly if the individual is unable to perform pressure relieving maneuvers... ~Heel Pressure Injuries: For individuals at risk of heel pressure injuries and/or with Category/Stage I or II pressure injuries, elevate the heels using a specifically designed heel suspension device or a pillow/ foam cushion. Offload the heel completely in such a way as to distribute the weight of the leg along the calf without placing pressure on the Achilles tendon and the popliteal vein... RECORD REVIEW On 07/13/2026, Surveyor reviewed Resident 2's closed record. Resident 2 was admitted to the facility on 07/16/2025 with diagnoses to include depression and pain. The record indicated Resident 2 had an APOA (Activated Power of Attorney) and was not receiving hospice services. A "Skin Check Shower Sheet" for Resident 2 dated 01/29/2026 indicated no open areas, redness or sores on the heels or buttocks. Surveyor requested all of Resident 2's 'Skin Check Shower sheets,' but the provider was unable to locate any additional 'Skin Check Shower Sheets' for the resident. Resident 2's most recent ISP (Individual Service Plan) dated 01/21/2026 indicated, the resident required staff assistance for dressing and ambulation, utilized a wheelchair for mobility and a mechanical lift for transfers. The ISP noted Resident 2 was incontinent of bowel and bladder, required staff assistance with hygiene and preferred to remain in bed for toileting at night.	Y3244		

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Y3244	Continued From page 5 Additionally, the ISP indicated the resident's skin was "intact and in good condition." On 07/13/2026 at 1:15 PM, Administrator A and Assistant Administrator E acknowledged Resident 2's ISP dated 01/21/2026 was the most current ISP for Resident 2. Review of Resident 2's observation notes indicated the following: *03/06/2026 at 8:15 AM, "Sore on butt, was cleaned and bandaged." *03/07/2026 at 3:35 PM, "New order for wound care to clean wound to right buttock with saline, apply bordered foam dressing to wound and change every three days as needed if dressing becomes soiled, saturated or loose." *03/15/2026 at 9:45 AM- "Resident is having a hard time with meds and has been more confused." *03/16/2026 at 5:45 AM- "Resident is more confused." *03/18/2026 at 7:45 PM- "Calling for wound care for resident in the morning." *03/24/2026 at 9:15 AM- "Needs to be sent to a wound clinic for possible wound vac! This wound needs attention..." *03/26/2026 at 12:00 PM, "Was sent out to the hospital due to wound on buttocks..." A physician fax for Resident 2 dated 03/06/2026 indicated, "Start mepilex dressing for wound care to right buttock. Order: Cleanse wound to right buttock with normal saline. Apply mepilex foam dressing to wound. Change every three (3) days and as needed if dressing becomes soiled, saturated or loose. Indication: Right buttock wound care and protection. Diagnosis- Open wound to right buttock. Please refer to wound care agency of choice for evaluation and	Y3244		

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Y3244	Continued From page 6 treatment of wound to right buttock." NOTE: On 03/20/2026, the provider sent a home health referral for Resident 2 and noted the reason as an 'open sore on buttocks.' The referral was delayed by fourteen (14) days following the initial physician's order on 03/06/2026. Additionally, no documentation was found confirming the ordered wound care and dressing changes were completed. The ED note for Resident 2 dated 03/26/2026 indicated, "Chief Complaint: Skin Problem: Pressure wound on buttocks per EMS...Pressure sore on each side of buttocks and lateral right heel present on admission to ED- Photos taken. [Resident 2] reports [s/he] had this ulcer for months...Diagnostic Imaging: Wound Infection, Pressure injury, unstageable with infection, most significant lesions located over right gluteal...Pressure injury of right buttock, Stage 4...ED COURSE: ...Physical exam of the right gluteal region revealed an approximately 12 cm area of erythema with a central 5 cm area of black eschar. The eschar was fluctuant to palpation, and the surrounding erythema was mildly warm. Over the left gluteal region, there was a 2.5 cm ulcer without significant surrounding erythema, warmth, or drainage. Additionally, there was a 2 cm ulcer over the right lateral heel without drainage, erythema, warmth, or tenderness. Overall findings were highly concerning for infection...[Resident 2] was started on vancomycin and Zosyn (antibiotics) in the ED after blood cultures were obtained. General surgery was consulted and recommended admission for IV antibiotics with later surgical evaluation and palliative care consultation. The hospitalist was consulted, and after discussion, we agreed to get an MRI to evaluate	Y3244			

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Y3244	Continued From page 7 osteomyelitis with plans to transfer to outside facility if positive for osteomyelitis...Non-contrast MRI demonstrated findings consistent with osteomyelitis of the right iliac crest with surrounding myositis, at which time ceftriaxone (an antibiotic) was added. The case was discussed with general surgery at transferring outside facility, who recommended hospital admission for IV antibiotics with surgical evaluation to follow. Physician accepted the resident for transfer. The resident was transferred in stable condition. DISPOSITION & DIAGNOSIS: Disposition: Transferred to another hospital on 03/26/2026. Diagnosis: 1. Osteomyelitis, unspecified site, unspecified type (HCC) 2. Wound infection 3. Pressure injury, unstageable, with infection (HCC) 4. Leukocytosis, unspecified type..." Resident 2's most current ISP dated 01/21/2026 did not include any interventions for pressure injury prevention or changes when the open area to the right buttock developed on 03/06/2026. The ISP did not include an effective plan to promote healing, prevent infection and avoid new pressure injuries from developing. It lacked specific interventions for preventive skin care, repositioning, nutrition and specialized support surfaces. INTERVIEWS On 07/13/2026 at 9:40 AM, Surveyor interviewed Caregiver F regarding Resident 2. Caregiver F indicated, Resident 2 required staff assistance with cares and transfers, did not ambulate, and spent a lot of time up in his/her wheelchair. Surveyor questioned Caregiver F about Resident 2's skin. Caregiver F stated, " [Resident 2] had a sore on [his/her] buttocks. [S/he] was admitted to	Y3244		

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Y3244	Continued From page 8 the hospital for debridement and never came back." Caregiver F verified s/he was unaware of the plan of care for Resident 2's "sore." On 07/13/2026 at 1:15 PM, Surveyor interviewed Administrator A and Assistant Administrator E about Resident 2. Administrator A and Assistant Administrator E verified Resident 2 was incontinent of bowel and bladder, required staff assistance with cares and transfers, and did not ambulate. Administrator A stated, "[Resident 2] would be up in [his/her] wheelchair most of the day and would lay in bed at night...When in bed [Resident 2] would lay on [his/her] back all night because [s/he] preferred to have a device that collects urine between [his/her] legs." Administrator A and Assistant Administrator E verified Resident 2 developed an open area to his/her right buttock on 03/06/2026, and confirmed the open area was "large and circular." Surveyor asked about the physician fax for Resident 2 on 03/06/2026. Administrator A and Assistant Administrator E verified they received the fax from Resident 2's physician on 03/06/2026 for wound care and dressing changes and a referral for the wound clinic. Surveyor asked for documentation the physician's orders were implemented and completed. Administrator A and Assistant Administrator E confirmed Resident 2's record lacked evidence wound care and dressing changes were completed and verified the wound clinic referral was not submitted until 03/20/2026. Surveyor then asked about Resident 2's ISP dated 01/21/2026. They both confirmed the ISP dated 01/21/2026 was the most current ISP for Resident 2, and acknowledged the ISP did not address the open area on Resident 2's right buttock and lacked staff interventions to promote healing, prevent infection and the development of new pressure	Y3244			

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Y3244	Continued From page 9 injuries. In conclusion, the provider did not make a timely referral to the wound clinic, complete wound care and dressing changes as ordered or develop and implement an appropriate plan of care to prevent and treat pressure injuries for Resident 2. Subsequently, the resident was transferred to the ED with an infected, unstageable pressure injury to the right buttock. Upon ED arrival, additional pressure injuries were discovered to the left buttock and right heel.	Y3244			