STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525663	A. Building B. Wing	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Beloit	2121 Pioneer Dr Beloit, WI 53511

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. (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 0686 Level of Harm - Actual harm 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 2 of 3 sampled residents (R1 and R6). (R6 is being cited at actual harm/isolated).R6 was identified to be at risk for PI development and re-developed a stage IV PI. Observations were made of PI interventions not being used as intended. Wound assessments were not completed weekly, and treatments were not completed as ordered. R6 re-developed a stage IV PI which deteriorated.R1's PI was not staged accurately. R1 did not have PI treatments completed as ordered. This is evidenced by:The facility's policy Wound Care Program, undated, includes: All residents admitted to our care will be comprehensively assessed for risk of and/or current pressure injuries or other alterations in skin integrity upon admission. A treatment plan will be initiated. Our wound protocol is based on the most recent NPIAP (National Pressure Injury Advisory Panel) pressure injury prevention and treatment guidelines. It is the expectation all new or worsening skin alterations will have thorough documentation including adding it to the current plan of care. Stage 2 Pressure Injury: Granulation tissue, slough and eschar are not present. Wound Assessment: Assessment of the wound is necessary prior to developing a plan of care. Assess the pressure injury initially and routinely thereafter and document findings. Wound Rounds It is the policy of [Facility Name] to make routine wound rounds on all resident with open wounds.Wound Rounds will be held on a routine basis in accordance with the NPIAP recommendations. Stage 2 Pressure Injury 4. Pressure redistribution to area: .pressure redistribution cushion to wheelchair. Stage 3 Pressure Injury 13. Pressure redistribution to the area.pressure redistribution cushion in wheelchair.Example 1R6 admitted to the facility on [DATE] and has diagnoses of a stage 4 pressure injury of the sacrum (healed in the facility), chronic venous hypertension with ulcer of bilateral lower extremity (a long-lasting sore that develops in the lower leg due to high pressure in the veins) and chronic myelomonocytic leukemia not having achieved remission (cancer of the blood-forming cells of the bone marrow). R6's comprehensive care plan, printed on 11/25/25, includes: Focus: R6 has chronic admit acq'd (acquired) PI stg (Stage) 4 sacrum resolved in house, recently reopened, hx (History) of (2) stage 2 PI L (Left) shoulder.Goal: will not develop and [sic] avoidable pressure injuries and current chronic resolved PI/scar tissue will remain stable/resolved.Interventions: Administer treatments as ordered and monitor for effectiveness. treatment to healed sacral wound for protection. Apply barrier cream during periods of incontinence/toileting and PRN (As Needed) to help prevent skin breakdown, monitor closely for inct (Incontinent) stools and assist as needed to keep clean and dressed. Check placement of protective foam to coccyx.every shift. Pressure redistribution mattress, pressure redistribution cushion to chair and recliner. Focus: R6 has an ADL (Activities of Daily Living) self-care performance deficit. Goal: R6 will be clean, dry and well-groomed daily.Interventions: Transfers/Ambulation: 1 assist with 2ww (2 Wheeled Walker) stand/pivot transfers. Dressing: 1 assist staff participation. Personal Hygiene/oral care: 1 assist staff participation.R6's physician orders state in part; start 6/18/25. Discontinue 10/30/25. Dermaseptin ointment (skin protectant with cooling menthol) to be applied to buttocks region with all incontinent cares and toileting.every shift. R6's Treatment Administration Record (TAR) states in part; start 6/18/25. Discontinue 10/30/25. Dermaseptin ointment (skin protectant with cooling menthol) to be applied to buttocks region with all incontinent cares and toileting.every shift.The TAR is blank for night shift on 10/1/25.The TAR is blank for day shift on 10/12/25 and 10/15/25. The TAR is blank for evening shift on 10/7/25 and 10/17/25.R6's physician orders state in part; start 9/8/25. Discontinue 10/17/25. Check placement of protective foam to coccyx.q (Every) shift.R6's TAR states in part; start 9/8/25. Discontinue 10/17/25. Check placement of protective foam to coccyx.q (Every) shift.The TAR is blank for day shift on 10/12/25 and 10/15/25. The TAR is blank for evening shift on 10/7/25.R6's physician orders state in part; start 9/22/25. Discontinue 10/31/25. Protective foam dressing to coccyx. Change every 3 days and PRN (As Needed) every day shift.R6's TAR states in part; start 9/22/25. Discontinue 10/31/25. Protective foam dressing to coccyx. Change every 3 days and PRN (As Needed) every day shift.The TAR is blank for 10/16/25, 10/19/25, 10/25/25, and 10/31/25.R6's Weekly Wound assessment dated [DATE]. Wound 3 Date of onset Site 3: 10/14/25. Where acquired: Facility-Acquired. Wound site: Coccyx. Type: Pressure. Length (cm): 3.2. Width (cm) 4.0. Depth (cm) 0.3. Stage: Stage IV. Wound Description/Tissue Type: granulation tissue, slough. Specify the percentage of each

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Actual harm 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 a resident's environment remained free of accidents and hazards for 1 of 3 residents (R3) reviewed for falls. R3 had a comprehensive care plan for being a high fall risk upon his admission on [DATE]. R3 experienced four falls at the facility since his admission. On 9/3/25, R3 experienced an unwitnessed fall without major injury. On 9/14/25, R3 experienced an unwitnessed fall with a subsequent left mandibular (lower bone of jaw) fracture. On 10/7/25, R3 experienced an unwitnessed fall without major injury. On 10/11/25, R3 experienced an unwitnessed fall with a subsequent left tenth rib fracture. R3's comprehensive care plan included interventions of having a urinal at bedside, a reacher and a call light within reach. Observations were made of R3 not having these interventions at bedside.Evidenced by:The facility policy entitled, Falling Star Policy, dated 11/2024, states, in part: The purpose of the Falling Star Program is to facilitate identification by all Facility's department personnel of the Residents who have experienced frequent falls and to dispatch immediate action to prevent further falls. 1) Participation in the Falling Star Program is determined by the IDT (Interdisciplinary Team) and Fall Committee after thorough review and evaluation. a) Frequent falls are defined as 2 or more falls in a month. b) The committee may include Residents as participants who have not fallen 2 or more times in a month through review and evaluation of high fall risk factors. 2) Falling Star participants are identified by the bright pink star logo which is affixed to the name plate outside of the resident's room, affixed to the assistive device, such as wheelchair and walker, and taped to the outside of the residents medical chart spine. 4) A list of Falling Star participants will be distributed to Department Heads and posted in the nursing station on each unit. 5) All Facility staff will respond to the Falling Star participants: a) If a Falling Star Participant is observed by any Facility personnel in an unsafe act that may cause a fall (i.e., unassisted transfers, reaching for an item on the floor, etc.) or a participant's request for help, the employee is to approach the participant and encourage the Resident to wait for help while summoning assistance from a direct caregiver. 6). The Fall Committee/IDT will routinely review the Falling Star participants to discuss continuation on the program.R3 was admitted to the facility on [DATE] with diagnoses that include: muscle wasting atrophy (degeneration of muscle mass), vascular dementia, adult failure to thrive, congestive heart failure (heart fails to pump blood effectively), atrial fibrillation (irregular heart beat), contracture of left hand (shortening of muscles in left hand causing hand to contract), low back pain, Cerebrovascular accident (stroke), hemiplegia (unilateral numbness) and hemiparesis (unilateral paralysis) following CVA affecting left dominant side.R3's admission Minimum Data Set, with Assessment Reference Date of 9/9/25, indicates R3 had a Brief Interview for Mental Status score of 5 out of 15, indicating severe cognitive impairment. Section GG indicates R3 has an upper and lower extremity impairment on one side and utilizes a walker and wheelchair for mobility. R3 is dependent on staff for lower body dressing, putting on/taking off footwear, and toileting hygiene. R3 requires substantial/maximal assistance for upper body dressing, shower/bathe self, chair/bed-to-chair transfer, toilet transfer, and tub/shower transfer. Section H indicates R3 is currently participating in a toileting program and is frequently incontinent of urine and bowel. R3's Minimum Date Set, with Assessment Reference Date of 10/7/25, indicates R3 had a Brief Interview for Mental Status score of 13 out of 15, indicating moderate cognitive impairment. Section GG now indicates R3 requires substantial/maximal assistance for lower body dressing, putting on/taking off footwear, and shower/bathe self. R3 requires partial/moderate assistance for toileting hygiene, upper body dressing, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, toilet transfer, walking 10 feet, walking 50 feet with two turns, and walking 150 feet.R3's first Fall Risk Assessment, dated 9/3/25, indicates R3 is at a high risk for falls with a score of 19. R3's Comprehensive Care Plan includes a Focus stating, [R3's Name] is at high risk for falls r/t (related to) recent hospitalization with muscle weakness, FTT (failure to thrive) and multiple recent falls, recent pneumonia, CVA (stroke) with left side weakness (left side is dominant side). Note that [R3's Name] is on anticoagulant (blood thinning) medications (Eliquis). Note that [R3's Name] was added to facility's Falling Star program upon admission. [R3's Name]'s room was moved closer to the nurses station for increased monitoring. Date Initiated: 9/3/25. Revision on: 10/1/25. Interventions: . Assist with ADLs (Activities of Daily Living), transfers, and toileting as necessary. (Refer to ADL for further information). Keep urinal at bedside. Assist to toilet and with HS (bedtime) cares in mid-evening. Hemi-walker with staff assist to help with balance. Date Initiated: 9/3/25. Revision on 10/1/25. Be sure R3's call light is within reach and encourage