STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525132	A. Building B. Wing	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Central Health Care	2400 Marshall Street, Ste A Wausau, WI 54403

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47657 Based on interview and record review, the facility failed to ensure a resident utilizing a Hoyer lift for transfers received adequate supervision and assistance devices to prevent accidents for 1 of 3 residents (R) (R1.) On [DATE], staff transferred R1 utilizing the incorrect sling type during a Hoyer lift transfer from chair to bed. As a result, R1 fell out of the incorrect Hoyer sling, hitting the right side of her face on the leg of the Hoyer lift. R1 had injuries of a nosebleed, and bruising to both eyes, forehead, and cheekbone. R1 expired on [DATE]. The medical examiner documented the cause of death as consequence of witnessed fall and complications of closed head injury. The facility's failure to ensure R1 had the correct type of sling for a safe Hoyer transfer created a finding of immediate jeopardy that began on [DATE]. Surveyor notified Nursing Home Administrator (NHA) A and Director of Nursing (DON) B of the immediate jeopardy on [DATE] at 4:15 PM. The facility took steps on [DATE], immediately after the incident, to correct the deficient practice and to ensure compliance. The immediate jeopardy was removed on [DATE] and the deficient practice was corrected on [DATE]. Based on this determination, the citation issued is past non-compliance. Findings include: The facility policy, entitled Safe Patient Handling and Movement, last revised on [DATE], section 3.5: Common Devices used at NCHC for full body lift states in part, Staff should always ensure correct sling size and type are used .see care plan for specific resident details. On [DATE], Surveyor reviewed R1's medical record. R1 was admitted on [DATE] with admission diagnoses of post femur fracture and anemia. R1 scored ,d+[DATE] during Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment. In February 2024, staff identified a decline in resident's status. R1 was placed on hospice for failure to thrive, osteoporosis, and weight loss. (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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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE], R1's care plan was updated from a stand pivot transfer to a Hoyer lift transfer with an hourglass sling. This change was made due to increased weakness and R1's inability to support own body weight. On [DATE], R1's care plan was updated from using an hourglass sling to a split leg sling, due to being unsafe because of the way R1 leans forward. On [DATE], R1's Power of Attorney (POA) was updated on R1 being more confused. R1's progress note, dated [DATE] at 6:30 PM, documents Registered Nurse (RN) C and Certified Nursing Assistant (CNA) D transferred R1 from chair to bed using an hourglass sling instead of a split leg sling. R1 leaned forward and fell out of the hourglass Hoyer sling hitting right side of face on the leg of the Hoyer, which resulted in bleeding from the nose. R1 was transferred back to bed, oxygen was administered, and hospice was updated. Vital signs at the time of the incident BP ,d+[DATE], P 156, Temp 102.1, resp 24, and O2 saturation 83%. Oxygen was administered at 2l/min and O2 saturation did not change so it was titrated up to 4l/min. Hospice arrived on [DATE] at 8:15 PM. Hospice talked to family about a possible broken nose. Hospice nurse called on call doctor about the fall and informed the POA/family that R1 was not a surgical candidate. POA/family opted not to send R1 to hospital for x-rays or evaluation. The facility documentation states an investigation began immediately, identifying the wrong type of sling was used for the transfer. The police were called at this time. On [DATE] at 2:27 AM, progress notes indicate R1 had dark purple bruising to both eyes, forehead and cheekbone, nosebleed and appeared swollen and purple with a small cut on the bridge, and signs of pain (grimacing). On [DATE] at 12:27 PM, R1 was placed on bed rest and nothing by mouth except for liquids for comfort due to decline. On [DATE] at 7:15 AM, R1 expired at the facility. On [DATE] at 8:30 AM, Surveyor interviewed CNA D over the phone and asked CNA D to explain the incident regarding R1's fall from the Hoyer lift. CNA D stated R1's daughter approached CNA D to lay R1 down as R1 was having trouble breathing. RN C started oxygen on R1 while R1 was sitting in the recliner. RN C felt R1 would be more comfortable in bed. CNA D stated not being aware of the sling type change because CNA D does not usually work that wing very often. The sling type was not discussed in 72-hour report. On [DATE], Surveyor attempted to contact RN C but was unsuccessful. On [DATE], Surveyor contacted medical director who stated inability to give details as the medical director was out of the country at the time and directed Surveyor to contact hospice. On [DATE] at 2:50 PM, Surveyor interviewed NHA A who had completed a reenactment of the incident. NHA A stated that R1 fell from the lift approximately 2 feet to the floor, hitting head on the leg of the Hoyer lift. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 12:55 PM, Surveyor interviewed Hospice Executive Director (ED) E via phone who stated that ED E was made aware of incident and at time of call did not have a copy of the death certificate or knowledge of medical examiner's result. On [DATE] at 1:00 PM, the facility received a fax of a Wisconsin Death Office Copy. Surveyor reviewed the document dated [DATE] by the medical examiner. The form documents manner of death: Accident Immediate cause: Complication of closed head injury due to or as a consequence of a witnessed fall. The facility's failure to ensure a resident utilizing a Hoyer lift for transfers received adequate supervision and assistance devices to prevent accidents created a reasonable likelihood that serious harm or death would occur, leading to a finding of immediate jeopardy that began on [DATE]. On [DATE], the facility identified the deficient practice when the staff used the incorrect sling type. The facility took steps to correct the deficient practice and ensure compliance on [DATE]. The immediate jeopardy was removed on [DATE] and corrected on [DATE], when the facility completed the following: Corrective actions were immediately put into place on [DATE], to ensure all residents who require mechanical lift transfers have the appropriate sling type and size. Removed Hoyer lift from service to be checked over by Biomed before using again. Removed staff involved from conducting any resident transfers pending investigation. Immediate education provided to all staff working on [DATE] and education continued for all staff as they came onto their shift. Removed full body lift from service to be checked over by Biomed before using again. Education started immediately via a read and sign on PSST (position, sling, size, type) importance of walking rounds and communication. Implemented sling audit to be completed at each shift change during walking rounds to verify correct sling continues to be used. The audit is ongoing and will be evaluated at QAPI. All residents requiring a full body lift or sit to stand lift were audited to validate that the care plan and the sling in the room matched. Educated all staff that slings should be laundered on the unit to always ensure availability of correct slings on the units. Signs were placed in all soiled linens rooms reminding staff to NOT send to central laundry to ensure correct sling size always available. Added hooks to the back of resident room doors to store slings in an easily accessible area. A visual of the sling types was posted on each full body lift. Online education-module was assigned to all nurses and CNAs including agency staff which included lifting techniques and sling details and had acknowledgment of understanding through a post module exam. This education was completed on [DATE], correcting the deficiency. Based on this determination, the citation is issued as past non-compliance.