

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525132	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/06/2024
NAME OF PROVIDER OR SUPPLIER  North Central Health Care		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 30570</p> <p>Based on record review and interview, the facility did not provide adequate supervision to prevent resident to resident incidents for 1 of 9 residents reviewed for accidents (R109).</p> <p>This is evidenced by:</p> <p>Surveyor requested and reviewed the facility policy which addresses resident to resident altercations. The policy titled Nursing Home Abuse, Neglect, Misappropriation, Exploitation, Resident to Resident . Resident to Resident Altercation: Negative, aggressive and intrusive verbal, physical material and sexual interactions between residents that in a community setting would likely be unwelcomed and potentially cause physical or psychological distress or harm in the recipient.</p> <p>Surveyor reviewed R109's record and noted admitted [DATE] with diagnosis that included alcohol induced encephalopathy, anxiety disorder, sleep disorder, degeneration of nervous system d/t (due to) alcohol, malnutrition, Wernicke's encephalopathy, non-Alzheimer's dementia. R109's power of attorney was activated.</p> <p>R109's admission MDS dated [DATE] notes resident sometimes understands is usually understood and has severely impaired cognition. R109 displays behavior directed towards others, rejects care and wanders daily. R109 is independent in transfer and ambulation with no range of motion impairments.</p> <p>Surveyor reviewed R109's Minimum Data Set (MDS) and noted:</p> <p>MDS most recent quarterly dated 5/01/24 notes resident sometimes understands, is usually understood and is severely impaired in cognition. R109 displays behavior directed towards others, rejects care and wanders daily. R109 is independent in transfer and ambulation. She has no range of motion impairments.</p> <p>Surveyor reviewed R109's care plan and noted:</p> <p>Resident will wander safely within specified boundaries.</p> <p>Actions</p> <p>Target Date: 05/02/2024 (Long Term Goal)</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Approach(s)</p> <p>Approach: Either CNA or Nurse to remain in the day room area during the overnight hours to provide redirection to residents wandering. Staff are to escort resident back to her room or occupy with meaningful activity in the day room where supervision is present.</p> <p>Approach: Resident lacks awareness of personal boundaries with peers. Will often mistake peers for close family members and offer hugs. Redirect from peers' rooms and personal spaces as needed.</p> <p>03/21/2024</p> <p>Approach: increased staff surveillance during high care activity times to redirect wandering as needed</p> <p>03/21/2024</p> <p>Approach: Equip resident with a device that alarms when resident wanders. Check for proper functioning of device every day.</p> <p>3/21/24: lacks awareness of personal boundaries with peers. Will often mistake peers for close family members and offer hugs. Redirect from peers' rooms and personal spaces as needed.</p> <p>5/07/24 chime alarm to door frame of resident room that sounds at nurses' station to alert staff to resident movements from room during overnight hours. When chime sounds staff are to escort resident back to her room or occupy with meaningful activity in day room where supervision is present</p> <p>Surveyor reviewed a Facility Reported Incident (FRI) during the facility recertification survey. The FRI indicated on 5/06/24 at approximately 4:30 am R74 was found on the floor next to her bed. R109 was in the room near R74. Positioning pillows that had been placed in bed with R74 were found placed on the dresser. Circumstances of how R74 came to rest on the floor are unknown, as both residents lack the cognitive ability to inform staff of what had happened. R74 sustained 2 skin tears to her right arm and a red mark to her right lateral knee.</p> <p>The facility responded to the incident on 5/6/24, with the following memo to nursing staff: Effective immediately the noc (night) shift nurse is not to take a care assignment for rounding The nurse will need to remain available in the common areas to provide supervision to residents in this area and monitor/respond to door alarms and resident movements into spaces where they should not be wandering.</p> <p>R109's care plan was updated to include: 5/07/24: chime alarm to door frame of resident room that sounds at nurses' station to alert staff to resident movements from room during overnight hours. When chime sounds staff are to escort resident back to her room or occupy with meaningful activity in day room where supervision is present.</p> <p>R109's nurses notes indicated:</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Behaviors: Both RN and CNA were in assisting a resident (R103) with repositioning at about 0410. Came out of room (R103's) and male CNA met up with resident (R109) in hallway at about 0415. Resident (R109) instantly angry, telling CNA to leave her house. Found resident (R109) and attempted to redirect. Resident (R109) continued to be very angry, went in a few of her neighbor's room. Attempted to redirect (R109) and resident went in and out of her room several times. Assisting another resident (R67) back to bed that R109 woke up. Resident (R109) very angry with this and stated, 'I'm going to call 911, you need to leave my home. though attempted to try to redirect (R109)but could not leave the other resident (R67). Resident (R109) went directly to phone at unit clerk station and called 911 at 0425. Writer called 911 to discuss resident (R109) that was on the phone with the other 911 person. During this time R109 came to get writer as the 911 dispatch wanted to talk with writer. 911 dispatch was OK with the call and hung up. Writer then had another staff member from a different unit come sit with resident (R109). About 20 minutes later resident (R109) calmer and is sitting in family room watching TV at this time. Discipline: Nursing. Date &amp; Time: 06/05/2024 05:05 e-Signed by Registered Nurse (RN) E.</p> <p>On 6/05/24 at 11:24 AM, Surveyor spoke with RN E about the incident earlier in the day. RN E indicated she has been on staff [AGE] years and usually works day shift. RN E explained she was present on R109's unit as RN E started at 2:00 am. today. RN E further expressed she comes in early one-two times a week and has worked R109's floor. RN E explained at about 4 am she and the nurse aide were in assisting another resident (R67) with repositioning. Both staff were in the room approximately 5-6 minutes and no staff were present at the nurse's desk. When the CNA walked out of the room, he met up with R109 in the hallway. She was not happy talking about being in her house. R109 was not happy, upset because they were in her house. Talked with R109, offered bed or TV with redirection. R109 kept saying they were in her house. R109 started walking in peers' rooms and they went with R109. R109 went back to her room and would come right back out. Staff offered R109 bed or other things, and R109 kept getting upset. The CNA was doing rounds and RN stayed with R67 after 109 woke R67. RN E explained she remained with R67 for a minute or 2 and did not summon the CNA to go supervise R109 when RN E stayed with R67.</p> <p>R109 was not supervised while RN E stayed with R67. At this time R109 called 911 from the phone at the desk. RN E explained she then called a nurse from another unit to come over and spend time with R109 and she then calmed down. Surveyor asked RN E if R109 was provided supervision and if her care plan to prevent resident altercations was followed. RN E indicated R109's care plan was not followed. Staff were not present at the nurse's desk to listen for R109's door chime and did not stay with and supervise R109 when she woke R67. Surveyor asked if not supervising R109 or following R109's care plan to prevent resident altercations placed other residents at risk for a potential peer to peer altercations; knowing R109 was upset. RN E responded, It may have.</p> <p>On 6/05/24 at 12:43 PM, Surveyor interviewed Director of Nursing (DON) B about the incident with R109 this morning. DON B explained the facility has a tracking system that showed RN E and the CNA were in R103's room assisting her for 5-6 minutes. Staff workflow was adjusted post peer to peer incident as part of follow up to FRI. Workflow included someone to stay at desk to be able to respond to R109's door chime if she rises on night shift to provide her supervision. Staff were not at desk to respond. R109 was heard in the hallway upset, she was going in and out of resident rooms. When R109 woke R67, RN E stayed with R67.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>30570</p> <p>Based on observation, interview and record review, the facility did not store, prepare and distribute foods in a sanitary manner. The facility's practices have the potential to affect 111 residents who eat orally.</p> <p>Cook F's facial hair/mustache was observed uncovered in the facility's kitchen where foods are prepared and stored.</p> <p>Equipment in the kitchen was observed uncovered while not in use in areas where food is prepared which has the potential for contamination of the equipment.</p> <p>Findings include:</p> <p>Example 1</p> <p>The facility's policy titled Safe Food Handling and Sanitation dated 5/31/23 in part read:</p> <p>General Procedure: Personal Appearance and Hygiene:</p> <p>Food service employees or any employees serving food to clients/residents .Hairnets shall cover 100% of the hairline, beard nets worn if not shaved.</p> <p>On 6/04/24 at 8:54 AM, Surveyor conducted an initial tour of the kitchen with Cook F. Surveyor and Cook F toured all food preparation and storage areas in the facility kitchen. Cook F was observed wearing a beard net that was worn below a full mustache that was not covered by the net. At no point during the tour did Cook F cover his mustache. Following the tour Surveyor asked Cook F about the facility expectation related to covering of facial hair in the kitchen including his mustache. Cook F responded it is expected all facial be covered in the kitchen including his mustache.</p> <p>On 6/05/24 at 10:43 AM, Surveyor spoke with Supervisor of Nutritional Services (SNS) G and Director of Nutritional Services (DNS) H about the observation with Cook F and the facility expectation related to hair restraint in the kitchen including facial hair. Both SNS G and DNS H indicated it is expected all hair including facial hair be covered in the kitchen.</p> <p>Example 2</p> <p>The facility's policy titled Safe Food Handling and Sanitation dated 5/31/23 in part read:</p> <p>Definitions:</p> <p>Cross-contamination means the transfer of harmful substances or disease-causing microorganisms to food by hands, food contact surfaces .</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Food contamination: means the unintended presence of potentially harmful substances, including but not limited to microorganisms, chemicals or physical objects in food.</p> <p>Cover all equipment with a garbage bag when no in use and at the end of the business day: this includes but not limited to small and large equipment (utensils, can openers, mixers, blenders etc.)</p> <p>On 6/04/24 at 8:54 AM during the initial tour, Surveyor observed a can opener and blender stored on the food preparation sink counter near the sink that has a garbage disposal in the sink. Both were not in use or covered. On the counter in another food preparation area Surveyor observed a small blender and can opener on the counter. Both were not in use and are not covered. Surveyor observed a steam jacket/kettle and robo-cup food processor that was not in use or covered. Surveyor asked Cook F about the equipment that was not in use and not covered. Cook F responded, Good point to cover. Surveyor asked Cook F if not covering the equipment when not in use has the potential for contamination, and Cook F responded there is a potential for contamination.</p> <p>On 06/04/24 at 9:30 AM, Surveyor spoke with SNS G about the expectation of covering equipment in the kitchen when it is not in use. SNS G responded equipment has the potential for contamination and should be covered if not in use.</p> <p>On 06/05/24 at 10:43 AM, Surveyor spoke with DNS H about the facility expectation of covering equipment when it is not in use. DNS H indicated all equipment in the kitchen needs to be covered when not in use.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40181</b></p> <p>Based on observation, interview and record review, the facility failed to properly prevent the spread of infections as evidenced by failure to sanitize mechanical lifts between 4 residents (R16, R62, R85, R71), did not provide hand hygiene for 6 of 111 residents (R109, R67, R22, R111, R112, R80) before eating, and did not perform proper hand hygiene between glove changes during cares for 1 resident (R71).</p> <p>Findings include:</p> <p>Facility policy and procedure entitled Cleaning, Disinfection, and Sterilization of Patient-Care Items, last revised 03/17/21, stated in part, Lift equipment/machines should be sanitized after each use with Purple Super Sani-Cloth wipes or 3M 40A.</p> <p>On 06/05/24 at 8:38 AM, Surveyor observed Certified Nursing Assistant (CNA) K bring a mechanical lift out of R16's room after using it to transfer R16 from bed to chair. Surveyor noted a sign outside R16's room identifying R16 was on Enhanced Barrier Precautions. CNA K placed the lift in hall outside R16's room and did not wipe the lift with a sanitizer wipe after use. At 9:46 AM, Surveyor observed CNA I bring the same mechanical lift into R62's room. CNA L joined CNA I and they used the lift to transfer R62 from chair to bed. They did not wipe the lift with a sanitizer wipe before bringing it into R62's room. At 9:53 AM, Surveyor observed CNA L bring the lift out of R62's room and place it in the hall outside the door. CNA L did not wipe the lift after using it to transfer R62. At 9:57 AM, Surveyor observed CNA I bring the same lift into R85's room. CNA I did not wipe the lift before bringing it into R85's room. CNA I and Registered Nurse (RN) E used the lift to transfer R85 to bed. After the procedure Surveyor observed CNA I take the lift out of R85's room, use hand sanitizer, put on gloves, and wiped the lift with a wipe from a purple topped container that was stored in a bag on the lift.</p> <p>On 06/05/24 at 10:41 AM, Surveyor interviewed RN J and asked the facility procedure for sanitizing mechanical lifts. RN J stated they are supposed to wipe the mechanical lifts after each use with a sanitizer wipe from the container kept on the lift.</p> <p>On 06/05/24 at 2:26 PM, Surveyor interviewed CNA M about the process for sanitizing mechanical lifts. CNA M reported they put gloves on and wipe down the lifts with a purple top wipe. CNA M stated they wait 2 minutes for the lift to air dry. CNA M stated they are to do this after each resident use.</p> <p>On 06/06/24 at 10:57 AM, Surveyor interviewed RN N, who oversees the infection prevention program for the facility, and informed of observation of staff not sanitizing lifts between residents. RN N stated they expected staff to wipe mechanical lifts with sanitizer wipes between each resident use. RN N stated staff had been educated on the procedure and there are bags on each lift with a purple top container of sanitizer wipes for their use.</p> <p>30570</p> <p>Example 2</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Surveyor requested and reviewed the policy titled Hand Hygiene Policy dated 4/03/24, the policy in part read:</p> <p>Purpose: Hand hygiene will be completed per the Centers of Disease Control (CDC) recommended guidelines</p> <p>Policy: To ensure the safety of those we serve and to prevent the spread of infection</p> <p>General Procedure: In order to perform hand hygiene appropriately soap, water, alcohol based hand rubs and a sink should be readily accessible in appropriate locations including but not limited to resident care areas, food .areas</p> <p>~Before and after eating.</p> <p>On 6/04/24 at 10:51 AM, Surveyor observed residents in the 4th floor dining room. The 4th floor is a dementia care wing. R109, R67, R22, R111, R112 and R80 were served beverages and cookies by CNA C and D. R109, R67, R22, R111, R112 and R80 were observed prior to the snack wandering about the unit. R109, R67, R22, R111, R112 and R80 were observed eating the cookies with their bare hands. R109, R67, R22, R111, R112 and R80 were not offered hand hygiene prior to being served and eating the cookies with their bare hands.</p> <p>R109 was observed ambulating around the unit and touching handrails and other items that are presumably dirty prior to being served the cookie. R67 was observed ambulating about unit touching various things before being served a cookie and beverages at table. Both are eating with their bare hands.</p> <p>R22 was observed propelling his wheelchair about unit before being brought to table and served a cookie that he ate with his hands.</p> <p>R111, R112 and R80 moved from chairs in activity that they were engaged in to chairs at tables in the dining room. They were served cookies that they ate with their bare hands. R111 was observed handling beads from a tackle box prior to being served a cookie. None were offered hand hygiene prior to eating.</p> <p>On 6/05/24 at 1:38 PM, Surveyor interviewed CNA C and D about the above observation and the expectation related to resident hand hygiene. Both indicated they did not think of hand hygiene, but it should have been offered prior to residents eating. The residents discussed are able to get around and hand hygiene needs to be done prior to eating. CNA C stated, It was wrong. I take full responsibility as I was training [CNA D] and I should know better.</p> <p>On 6/05/24 at 2:40 PM, Surveyor interviewed RN N, who is the facility's infection control preventionist about the observation and her expectation related to resident hand hygiene. RN N indicated she would expect hand hygiene to be offered to residents in any activity involving food. RN N further indicated residents on the 4th floor/dementia wing get around and into everything and should have hand hygiene before eating whether it's a meal, snack or activity involving food.</p> <p>47807</p> <p>Example 3</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The facility policy, entitled Hand Hygiene Policy, dated 04/03/24, states: 4.1.1 Staff must preform hand hygiene (even if gloved are used):</p> <p>4.1.1.1 Before and after contact with the resident following a care procedure</p> <p>4.1.1.2 Before performing an aseptic task</p> <p>4.1.1.3 After contact with blood, body fluids, visibly contaminated surfaces, or after contact with objectives in the residents room:</p> <p>4.1.1.4 After removing personal protective equipment (e.g., gloves, gown, facemask):</p> <p>R71 was admitted to the facility on [DATE] with diagnoses of paraplegia, a history of sepsis, colostomy, and a history of pressure ulcers.</p> <p>R71's most recent Minimum Data Set (MDS) completed on 04/19/24 indicated a Brief Interview for Mental Status (BIMS) Score was 15, indicating cognitively intact.</p> <p>On 06/05/24 at 7:35 AM, Surveyor observed cares for R71. CNA O donned a gown and gloves to perform a bed bath and get R71 ready for the day. CNA O washed R71 using a warm washcloth including the peri area. After completing the washing, CNA O removed gloves and went over to the dresser to get new clothing for the day. CNA O did not perform hand hygiene after the glove change. CNO O handed the clean clothing to R71. CNA O then donned new gloves and continued with cares without performing hand hygiene. Surveyor interviewed CNA O regarding the lack of hand hygiene used in between glove changes. When asked, CNA O apologized and said that they forgot to perform hand hygiene after removing their gloves.</p> <p>On 06/05/24 at 7:44 AM, Surveyor observed CNA P enter the room with a Hoyer lift to help transfer R71 to their electric chair. After the transfer, CNA P rolled the Hoyer lift into the hall and left it across from R71's room in the main hallway. Both CNA O and CNA P left the area without wiping down the Hoyer lift with the wipes that were attached to the cart. Surveyor followed both CNAs to the dining room where they started to perform tray duty, bringing breakfast to residents eating in the dining room. Surveyor asked both CNAs if it was normal to leave the Hoyer Lift without wiping it down after use. CNA P said no that is not, and they must have forgotten to wipe it down, normally they wipe down the lifts after each use when they leave it In the hallway. Surveyor asked if someone else could use the Hoyer lift for a different resident with both CNAs now in the dining room, to which both CNAs indicated yes it was possible.</p> <p>On 06/05/24 at 8:17 AM, Surveyor observed CNA O emptying R71's colostomy bag. CNA O donned gown and gloves and performed hand hygiene before donning gloves. CNA O placed a clean cloth below the colostomy bag and opened the bag. CNA O emptied contents into a urinal using towels to keep area clean. Contents were exposed at this point and CNA O emptied the contents of the urinal into the toilet and washed out the urinal. CNA O then removed gloves and donned new gloves to continue cares; no hand hygiene was used in between glove changes. CNA O continued by closing the colostomy bag and tucking the colostomy bag back into the resident's pants. Surveyor then asked CNA O if they had performed hand hygiene after handling the contents of the colostomy bag to which CNA O said they had not, they had just forgotten to do it.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 06/06/24 at 9:18 AM, Surveyor interviewed Charge Nurse (CN) Q, who oversees nursing operations on the second floor north and second floor south on what they would expect as far as hand hygiene in-between glove changes and wiping down Hoyer lifts after use. CN Q said they would expect hand hygiene after removing gloves during care and/or before donning new gloves during care. They would also expect the lifts to be wiped down after each use.</p>		