STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525353	A. Building B. Wing	05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stevens Point Health Services	1800 Sherman Ave Stevens Point, WI 54481

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 - Minimal harm or potential for actual harm 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** 40342 Based on observation, staff and resident interview, and record review, the facility did not ensure adequate fall prevention interventions were in place for 3 residents (R) (R36, R10, and R291) of 3 sampled residents. R36 fell on [DATE] and 3/18/24. The facility did not implement new fall interventions to prevent future falls. R36 fell again on 3/22/24. R10 was admitted to the facility following a fall with a fracture at home. R10 had a rug in R10's room with curled edges. The facility did not develop a comprehensive falls care plan, including R10's preference and risk for keeping the rug in R10's room. R291's smoking materials were to be stored securely by staff. During an observation on 5/7/24, smoking materials were observed in R291's room. Findings include: The facility's Fall Prevention and Management Guidelines policy, with review date of 11/8/22, indicates: Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized plan of care to minimize the likelihood of falls or reduce the possibility/severity of injury .7. When any resident experiences a fall, the facility will: a. Complete a post-fall assessment and review: .6) Contributing factors to the fall .d. Review the resident's care plan and update with any new interventions put in place to try to prevent additional falls . The facility's Accidents and Supervision policy, with a revised date of 7/14/22, indicates: The facility shall establish and utilize a systemic approach to address resident risk and environmental hazards to minimize the likelihood of accidents. a. All staff are to be involved in observing and identifying potential hazards in the environment while taking into consideration the unique characteristics and abilities of each resident. i. Resident-directed approaches may include: implementing specific interventions as part of the plan of care. The facility's Smoking policy, with an effective date of 5/2019, indicates: 9. Residents who are assessed to require supervised smoking will have nicotine materials secured in a container that is maintained by the licensed nurse. (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 - Minimal harm or potential for actual harm Residents Affected - Few	1. On 5/6/24, Surveyor reviewed R36's medical record. R36 was admitted to the facility on [DATE] with diagnoses including left femur (long bone in upper leg) fracture and unspecified dementia without behavioral disturbance. R36's Minimum Data Set (MDS) assessment, dated 4/4/24, stated R36's Brief Interview for Mental Status (BIMS) score was 7 out of 15 which indicated R36 had severely impaired cognition. R36's medical record indicated R36's Power of Attorney for Healthcare (POAHC) was responsible for R36's healthcare decisions. R36 was discharged from the facility on 4/30/24. On 5/7/24, Surveyor reviewed a fall investigation that indicated R36 was found on the floor on 3/14/24. The investigation indicated the facility added non-skid socks/shoes and auto-lock wheelchair brakes to R36's care plan. A fall investigation indicated R36 was found on the floor again on 3/18/24. The fall investigation indicated the facility again added non-skid socks/shoes and auto-lock wheelchair brakes to R36's care plan. In addition, a fall investigation indicated a nurse observed R36 start to stand up from R36's wheelchair on 3/22/24 but was unable to reach R36 before R36 slipped from the wheelchair onto the floor with the wheelchair cushion in R36's grip. The facility provided a non-slip pad and a better size cushion for R36's wheelchair. On 5/7/24, Surveyor reviewed R36's care plan which indicated non-skid socks/shoes were added on 1/2/24. In addition, the care plan indicated auto-lock brakes were added on 2/21/24. On 5/7/24 at 9:35 AM, Surveyor interviewed Director of Nursing (DON)-B who indicated the facility did staff training related to root cause analysis of falls and making sure new interventions make sense but did not document the education. DON-B verified the facility should have added new interventions to R36's care plan following R36's falls on 3/14/24 and 3/18/24. 43361 2. Between 5/6/24 and 5/8/24, Surveyor reviewed R10's medical record. R10 was admitted to the facility on [DATE] following a left femur fracture and hip surgery following a fall at home. R10 had a guardian and diagnoses including dementia and polyneuropathy. R10's MDS assessment, dated 3/1/24, stated R10 had a BIMS score of 3 out of 15 which indicated R10 had severely impaired cognition. R10's medical record contained a care plan, initiated on 12/8/23, with a focus statement that indicated R10 was at risk for falls due to a history of falls. The care plan contained one intervention that indicated: Fall Risk (FYI) (initiated on 12/8/23). During multiple observations between 5/6/24 and 5/8/24, Surveyor observed R10 ambulate independently throughout the unit and in R10's room. On 5/6/24 at 11:07 AM, Surveyor observed R10's room and noted R10's bed was placed in the middle of the room with the head of the bed against one of the walls. Surveyor observed a multicolored rug that was approximately 4 feet by 6 feet on the floor next to the bed. The corners of the rug were curled up. R10 was not in the room. On 5/8/24 at 10:03 AM, Surveyor observed R10 stand on the rug and attempt to make R10's bed. Surveyor observed a pile of blankets on the bed and watched R10 shuffle around the room. On 5/8/24 at 10:16 AM, Surveyor interviewed Registered Nurse (RN)-U who indicated RN-U previously expressed concern about the rug. RN-U indicated R10 was particular and would be upset if the rug was removed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/8/24 at 11:34 AM, Surveyor interviewed DON-B who indicated staff tried to get the rug out of R10's room, but R10 was adamant that R10 wanted the rug. Surveyor asked if a risk versus benefit statement was completed, if staff consulted with R10's guardian, and if the rug should be noted on R10's care plan. When Surveyor showed DON-B R10's current falls care plan, DON-B confirmed the care plan should indicate more than that R10 was a fall risk. DON-B agreed R10's rug was a trip hazard and indicated staff would follow up about the rug. 50479 3. Between 5/6/24 and 5/8/24, Surveyor reviewed R291's medical record. R291 was admitted to the facility on [DATE] with a past medical history including tobacco dependence, brain cancer, and epilepsy. A care plan, dated 5/2/24 with a target date of 7/31/24, indicated R291 opted to continue smoking cigarettes and R291's smoking safety was determined by a smoking assessment. A smoking assessment, dated 5/4/24, indicated R291 required supervision with nicotine products and R291's smoking materials should be stored with facility staff. On 5/7/24 at 1:02 PM, Surveyor observed R291 alone in R291's room. Surveyor observed a pack of cigarettes and a lighter on R291's bedside table. Surveyor interviewed R291 who stated staff escort R291 to the facility's designated smoking areas and supervise R291 when R291 smokes. R291 stated R291's cigarettes and lighter were stored in R291's room and indicated staff did not secure R291's smoking materials. On 5/7/24 at 1:10 PM, Surveyor interviewed Registered Nurse (RN)-S who confirmed R291 required staff supervision when smoking. On 5/7/24 at 1:33 PM, Surveyor interviewed Certified Nursing Assistant (CNA)-R who was unaware R291 smoked and was not familiar with the facility's smoking policy. On 5/7/24 at 1:15 PM, Surveyor interviewed Assistant Director of Nursing (ADON)-C who stated the facility's expectation is that smoking materials are kept locked in the medication cart.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40342 Based on staff interview and record review, the facility did not ensure effective pain management was provided for 1 resident (R) (R91) of 1 resident reviewed for pain management. R91 was not provided effective pain management in a timely manner on 3/18/24. Findings include: The facility's Pain Management policy, with a review date of 8/9/22 indicates: The facility must ensure pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences .1. To help a resident attain or maintain his/her highest practicable level of physical, mental and psychosocial well-being and to prevent or manage pain, the facility will: a. Recognize when the resident is experiencing pain and identify circumstances when the pain can be anticipated .c. Manage or prevent pain, consistent with the comprehensive assessment and plan of care, current professional standards of practice, and the resident's goals and preferences. 2. Facility staff will observe for nonverbal indicators which may indicate the presence of pain . The facility's Emergency Pharmacy Services and Emergency Kits (E-Kits) policy, dated 1/24, indicates: Emergency pharmaceutical service is available on a 24-hour basis .14. The emergency medication kit may contain controlled substances .b. Contact the pharmacy immediately if a new order for controlled medication is needed from the E-Kit and follow the procedures outlined below. An authorization code from the pharmacist is required prior to entering the controlled E-Kit .Once the prescriber has determined that the order meets the definition of 'Emergency Situation', the nurse must contact the pharmacist for an authorization to access the E-kit. The valid prescription requirement can be met in 2 ways: 1. An emergency verbal order communicated directly from the authorizing prescriber to the pharmacist. 2. A hard copy prescriber signed prescription is faxed by the prescriber or agent of prescriber or transmitted to pharmacy .If a hard copy of the prescriber signed prescription is available: 1. Nurse will contact the pharmacist to communicate the need to access the E-kit. 2. Nurse will fax hard copy prescription to the pharmacist. 3. Once pharmacist confirms receipt of a valid prescription, pharmacist will contact facility nurse to communicate: Authorization .4. Nurse will send hard copy to pharmacy with the next pharmacy delivery . On 5/6/24, Surveyor reviewed R91's medical record. R91 was admitted to the facility on [DATE] with diagnoses including right femur (long bone in upper leg) fracture. R91's Minimum Data Set (MDS) assessment, dated 2/25/24, stated R91's Brief Interview for Mental Status (BIMS) score was 9 out of 15 which indicated R91 had moderately impaired cognition. R91's medical record indicated R91 was responsible for R91's healthcare decisions until R91's Power of Attorney for Healthcare (POAHC) was activated on 3/18/24. R91 passed away at the facility on 3/19/24. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note, dated 3/18/24, indicated: Writer received orders from Hospice on fax machine. Writer entered morphine (used to treat moderate to severe pain) order and put in request to medication contingency to remove. Writer contacted pharmacy and they stated they did not receive prescription from Hospice. Writer contacted Hospice twice and asked two different people to give a message to the nurse that pharmacy did not receive the prescriptions from the physician and they both stated they would relay the message. Writer updated that (R91) was yelling out and in a lot of pain. Writer contacted pharmacy again and spoke with 2 staff members who stated writer could fax the signed prescription for morphine and they could give authorization to pull the medication. Writer faxed morphine prescription to pharmacy. Writer received confirmation at 6:33 PM that the order was received. Writer called pharmacy and spoke with staff member who stated the pharmacist was on break and would call back in ten minutes. Writer called pharmacy back in 15 minutes and spoke with pharmacist who provided an authorization number. Writer and Registered Nurse (RN) attempted to pull from contingency but it stated pending confirmation. Writer called pharmacy and spoke with the after hours pharmacy. Writer waited on hold for 30 minutes and spoke with another pharmacy staff who stated the pharmacist gave a new authorization number. Pharmacy staff waited on the phone until writer was able to pull the morphine. R91's March 2024 Medication Administration Record (MAR) contained an order, dated 3/18/24, for morphine sulfate (concentrate) oral solution 20 mg/ml (milligrams per milliliter) give 0.25 ml by mouth every 2 hours as needed for pain or shortness of breath. The MAR indicated R91 received the first dose of morphine on 3/18/24 at 7:58 PM which was effective. R91's medical record contained a controlled substance order in prescription format, dated 3/18/24, for the morphine order on R91's MAR. A fax imprint on the form indicated the facility received the faxed order on 3/18/24 at 3:02 PM. On 5/6/24 at 4:02 PM, Surveyor interviewed RN-N via phone. RN-N verified RN-N documented the above nurse progress note. RN-N indicated RN-N felt so bad for R91 because RN-N was not able to obtain R91's pain medication timely from the emergency kit. RN-N stated, (R91) was yelling out, moaning. Not loud. No words used .every once in a while cried out. RN-N indicated RN-N believed the Hospice nurse was going to fax the morphine prescription to the facility's contracted pharmacy and stated, That's what (Hospice nurse) told me. RN-N indicated the facility had a PIXUS machine provided by the pharmacy for emergency use of medications. RN-N indicated nurses need to enter a request into the machine, call the pharmacy to get an authorization code for the nurse to obtain the controlled substance, and have a second nurse verify so the medication can be removed from the machine. RN-N stated the first person RN-N spoke to at the pharmacy told RN-N the prescription needed to come directly from Hospice which was why RN-N tried to get Hospice to send the prescription to the pharmacy. RN-N indicated by the time the medication could be obtained from the machine, staff for the next shift were at the facility and the next shift nurse gave the first dose of morphine to R91. On 5/6/24 at 4:31 PM, Surveyor interviewed RN-O via phone who verified RN-O gave R91 the first dose of morphine on 3/18/24. RN-O indicated R91 also had an order for tramadol (used to treat moderate to severe pain) in pill form, but R91 could no longer swallow well and needed medication in liquid form. RN-O indicated R91 was calling out, tense and showing signs of pain. RN-O indicated RN-O started RN-O's shift on 3/18/24 at 6:00 PM and actively tried to get pain medication for R91. RN-O indicated R91's family was with R91 and stated, Family didn't want (R91) to be in pain anymore. RN-O verified RN-O gave R91 the first dose of morphine as soon as RN-N could get the medication out of the machine. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/7/24 at 9:50 AM, Surveyor interviewed Director of Nursing (DON)-B who indicated the process for obtaining controlled substances from the PIXUS machine was difficult and indicated the facility was having problems with pharmacy. DON-B stated, I constantly have to send screen shots of e-scripts previously sent to pharmacy .Sometimes we get access for a few pills to tide us over. DON-B verified 3:00 PM until receipt of pain medication at 7:58 PM was a long time for R91 to be in pain. DON-B stated, We are supposed to be able to get an access code and get access (to medications) within 30 minutes. That's what we are told by pharmacy .It (the process failure) is delaying pain medication .It's a big deal, the delay of pain meds. I babysit every admission to communicate with pharmacy. The nurses are busy. They don't have time .This is an on-going issue .