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	11/06/2024

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40449 Based on observation, staff and resident interview, and record review, the facility did not ensure 2 residents (R) (R1 and R3) of 3 sampled residents received the necessary care and services to prevent and heal pressure injuries. R1 was admitted to the facility following a fall with fractures and had bilateral splints to the lower extremities. The splints were not removed for skin checks and R1 developed an unstageable deep tissue injury (DTI) on the right heel. In addition, R1 had a pressure injury on the sacrum that was allegedly present upon admission on 10/1/24. Treatment was not initiated until 10/4/24 and air mattress was not ordered until 10/11/24. R3 was admitted to the facility on [DATE] with a pressure injury on the left heel. A wound assessment and treatment order were not obtained until 5/15/24. The facility did not complete weekly wound assessments or notify the wound clinic when the wound had purulent (containing pus) exudate and appeared infected. Findings include: The facility's Pressure Injuries and Non pressure Injuries policy, with a review date of 7/20/22, indicates: Pressure injury refers to localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. A pressure injury will present as intact skin and may be painful. A pressure ulcer will present as an open ulcer, the appearance of which will vary depending on the stage and may be painful. The injury occurs because of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by skin temperature and moisture, nutrition, perfusion, co-morbidities, and condition of the soft tissue .Medical device-related pressure injuries result from the use of devices designed and applied for diagnostic or therapeutic purposes. The resultant pressure injury generally conforms to the pattern or shape of the device. The injury should not be staged using the staging system .A head-to-toe body evaluation will be completed on every resident upon admission/readmission .If skin is compromised: I. If pressure injury: Initiate the Pressure Injury Weekly Tracker; Ensure primary care physician is aware of wounds/location of wounds and current treatment orders; Ensure appropriate treatment orders for each wound area .2. Weekly: a. Complete a head-to-toe skin check and document findings on the Skin Review-Weekly. If new areas are present: Notify the Pysician; Initiate a treatment per order; .Update plan of care; b. Assess current wounds at least every seven days or more frequently. (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 0686 Level of Harm - Actual harm Residents Affected - Few	1. From 11/5/24 to 11/6/24, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] following a fall with fractures and had diagnoses including chronic kidney disease, high blood pressure, and bilateral ankle fractures. R1's Admission Minimum Data Set (MDS) assessment, dated 10/8/24, had a Brief Interview for Mental Status (BIMS) score of 10 out of 15 which indicated R1 had moderate cognitive impairment. The MDS also indicated R1 was at risk for pressure injuries, had no pressure injuries upon admission, and required moderate to max assistance with activities of daily living (ADLs) and mobility. R1's plan of care indicated R1 had potential/actual impairment to skin integrity related to incontinence and impaired mobility and a stage III to coccyx and a SDTI (suspected deep tissue injury) to the left (sic) heel. The care plan contained interventions for a cushion in wheelchair, heel boots/risers when in bed, float/elevate heels, and an air mattress. A hospital discharge summary, dated 10/1/24, indicated R1's left ankle X-ray showed an acute, nondisplaced infrasyndesmotic distal fibular (long bone in the lower leg that runs alongside the shin bone) fracture. R1's right ankle X-ray showed an acute, nondisplaced intra-articular medial malleolar (ankle) fracture. The discharge summary indicated R1 had bilateral splints placed on the lower extremities and was non-weight bearing status. On 10/4/24 at 4:49 AM, a Certified Nursing Assistant (CNA) reported an open area on R1's right buttock. An assessment indicated the area appeared to be shearing-related and measured 3.8 centimeters (cm) x 1.6 cm x less than 0.1 cm. The surrounding skin was blanchable and contained what appeared to be scar tissue. The wound bed was a mix of intact skin and granulation tissue. A treatment was entered on 10/4/24 to cleanse the wound and apply a foam dressing daily and as needed (PRN). A weekly skin review, dated 10/8/2024 at 3:27 PM, indicated R1 had a pressure injury on the right buttock and bilateral ankle surgical wounds that were healing. An orthopedic note, dated 10/8/24, indicated to fit R1 with an Ankle Stabilizing Orthosis (ASO) for the left ankle and a walker boot for the right ankle. The note indicated the right ankle boot should be on whenever R1 was up and about and a posterior splint should be used for comfort with sleep. The facility's Social Worker (SW) ordered an air mattress for R1 on 10/11/24 (which was 7 days after the discovery of the buttock wound and 10 days after R1 was admitted to the facility). A wound physician initial evaluation, dated 10/16/24, indicated R1 had an unstageable pressure wound on the right sacrum that measured 2.5 cm x 1.5 cm x 0.1 cm with necrosis and moderate serosanguinous (a combination of blood and serum that's often a sign of healthy wound healing) exudate that was present upon admission per staff. Recommendations indicated to off-load the wound and reposition per facility protocol. An orthopedic note, dated 10/22/24, indicated R1 had a posterior splint to the right ankle and an ASO to the left ankle. R1 complained of discomfort regarding the left ASO and took Tylenol for pain. The right splint was removed. There was resolving ecchymosis (bruising) and a healing abrasion on the right shin. R1 was switched to walker boots for both ankles. The note stated boots may be off for seated showering. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A wound physician note, dated 10/30/24, indicated R1 had a stage 3 pressure wound on the right sacrum that measured 1.5 cm x 0.5 cm x 0.2 cm with light serous drainage that was improving and an unstageable DTI with undetermined thickness on the right heel that measured 3.0 cm x 2.0 cm. The note contained recommendations for a pressure off-loading boot, float heels in bed, off-load wound, and reposition per facility protocol. On 11/5/24 at 11:00 AM, Surveyor observed R1 in bed on an air mattress with a pillow between R1's knees. R1's heel boots were next to the bed. At 11:30 AM, Surveyor observed R1 in bed on a bedpan without heel boots. At 12:00 PM, staff completed cares in R1's room. At 12:30 PM, Surveyor observed R1 eating lunch in bed without heel boots. At 1:30 PM, Surveyor observed R1 in bed with heel boots on and heels floated. At 4:05 PM, Surveyor observed R1's right sacrum with Director of Nursing (DON)-B and Occupational Therapist (OT)-M and noted R1's sacral pressure injury was approximately 2.0 cm x 2.0 cm. The center of the wound contained moist granulation tissue and the surrounding tissue was intact. On 11/6/24 at 2:35 PM, Surveyor interviewed DON-B who indicated R1 wore a brace on the right lower extremity from 10/1/24 to 10/22/24. When Surveyor asked if the brace was removed for skin checks, DON-B indicated the brace was not removed. DON-B provided Surveyor with documentation from the orthopedic clinic, dated 11/5/24, that indicated R1's splints were to be kept on until follow-up with the orthopedic clinic. (The documentation was not obtained until after Surveyor inquired if the splints were removed for skin checks.) DON-B indicated the facility did not have a policy that addressed skin care and the use of medical devices. DON-B was unaware if staff contacted the orthopedic clinic prior to 11/5/24 regarding the use of the splints and if staff could remove or open the splints to complete skin checks. On 11/6/24 at 3:00 PM, Surveyor interviewed Nurse Practitioner (NP)-L regarding the cause of R1's right heel DTI. NP-L indicated the DTI was a facility-acquired wound and not a result of R1's fall prior to admission as R1 was not on the ground for an extended period of time following the fall. 2. From 11/5/24 to 11/6/24, Surveyor reviewed R3's medical record. R3 was admitted to the facility on [DATE] with diagnoses including sepsis with shock due to pyelonephritis (kidney infection) and possible right kidney abscess, diabetes mellitus, peripheral venous insufficiency, and chronic kidney disease. R3's Admission MDS assessment, dated 9/5/24, had a BIMS score of 14 out of 15 which indicated R3 was not cognitively impaired. The MDS also indicated R3 had a stage 2 pressure injury that was present upon admission. R3's plan of care indicated R3 had skin impairment due to a pressure ulcer on the left heel related to impaired mobility and indicated R3 chose to not elevate the foot or use a heel riser at times. Interventions included an air mattress, encourage and assist as needed to turn and reposition, use assistive devices as needed, use pillows and/or positioning devices as needed, and float heels/use heel riser as R3 allowed. Risk versus benefit education was provided regarding the importance of elevating the foot to help facilitate wound healing. R3's plan of care also indicated R3 had a left heel infection and contained interventions to monitor for side effects from antibiotic therapy and report worsening signs/symptoms of infection or lack of improvement from treatment to the physician. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A note, dated 5/15/24, indicated R3 had stage 1 pressure injury on the left heel that measured 9.5 cm x 11 cm with no drainage and a left heel/ankle protector boot was placed. A treatment was initiated to paint the pressure injury with Betadine, apply Aquacel AG (a hydrofiber wound dressing that contains ionic silver), and cover with an adhesive heel foam dressing. A Pressure Injury Weekly Tracker, dated 5/17/24, indicated R3 had a left heel pressure injury that was present upon admission. The surface area was greater than 24 cm with moderate drainage. There was inflammation/induration surrounding the wound but no infection suspected. The tracker indicated it was the first observation of the wound. The Plan/Treatment section contained a late entry that indicated R3 was newly admitted to the facility and was referred to the wound clinic. The earliest appointment available was 6/12/24. The tracker indicated staff would continue the current treatment until a new order was received from the wound clinic. R3's medical record did not contain an assessment of the pressure injury from 5/18/24 to 5/28/24. R3 was admitted to the hospital on 5/28/24 and discharged from the hospital on 6/3/24 with diagnoses including severe sepsis due to urinary tract infection (UTI), hypotension, and acute respiratory failure. R3's medical record did not contain an assessment of the pressure injury from 6/3/24 to 6/23/24. A wound clinic note, dated 6/24/24, indicated R3 was seen for follow-up of the left heel ulcer which contained a copious (large) amount of purulent green exudate. The note indicated the facility did not notify the wound clinic of the change in condition. The note indicated R3 had an infected diabetic ulcer on the left heel with necrosis of muscle and the writer suspected R3 had pseudomonas (a bacterial infection that can be severe in people with weakened immune systems) due to the heavy green exudate. Recommendations indicated to change the left heel dressing daily due to infection, use heel foam boots to suspend heels when in bed, keep legs and feet dry/avoid soaking or getting wet, and follow-up on 7/15/24. Weekly skin reviews, dated 7/1/24, 7/8/24, and 7/15/24, indicated R3 had a pressure wound on the left foot. The reviews did not contain measurements or an assessment of the pressure injury. R3's medical record did not contain an assessment of the pressure injury from 6/25/24 to 7/14/24. An Advance Practice Nurse Prescriber (APNP) note, dated 7/15/24, contained a new treatment order, but no measurements or description of the left heel wound. R3's medical record did not contain an assessment of the pressure injury from 7/16/24 to 8/1/24. R3 was admitted to the hospital on 8/1/24 and discharged from the hospital on 8/12/24 with diagnoses including severe sepsis due to UTI and acute metabolic encephalopathy. On 11/5/24 at 2:15 PM, Surveyor interviewed R3 and observed an air mattress on R3's bed and a cushion on R3's wheelchair. R3 indicated R3's left heel wound developed in the facility. R3 indicated R3 refused heel boots, but allowed staff to elevate R3's heels with a pillow. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 11/5/24 at 11:10 AM, Surveyor interviewed DON-B and Assistant Director of Nursing (ADON)-C regarding the lack of weekly pressure wound assessments for R1 and R3. DON-B and ADON-C could not provide additional information and indicated the assessments were not completed. On 11/5/24 at 3:30 PM, Surveyor interviewed DON-B and Regional Consultant (RC)-F. DON-B indicated DON-B was aware of the facility's lack of weekly charting/documentation and indicated a Performance Improvement Plan (PIP) was put in place to address the facility's wound care process. DON-B and RN-F indicated the facility had a meeting last Friday (11/1/24) related to nutrition and wounds and were updating care plans. DON-B and RN-F indicated the facility would do skin assessments on all residents and then complete staff education. The PIP indicated the wound care process concern was identified on 10/28/24 and the facility would complete skin and Braden scale assessments on all residents from 11/4/24 to 11/9/24 and review and revise care plans as needed. The PIP also indicated licensed nursing staff would not be educated on the wound care process until a nurses' meeting on 11/13/24. On 11/6/24 at 12:16 PM, Surveyor interviewed RC-E regarding the facility's Pressure Injuries and Non pressure Injuries policy. RC-E indicated the policy stated weekly assessments should be done for pressure injuries. RC-E indicated staff did not follow the facility's policy when they did not complete weekly assessments. On 11/6/24 at 1:18 PM, Surveyor again interviewed RC-E regarding wound care. RC-E indicated staff did not follow standards of practice or the facility's wound care policy. X0440

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 40449 Based on observation, resident and staff interview, and record review, the facility did not ensure proper infection control practices were maintained related to the use of personal protective equipment (PPE) for 2 residents (R) (R2 and R3) of 2 residents who were on enhanced barrier precautions (EBP). R2 was on EBP due to urinary concerns. Staff did not don the appropriate PPE during the provision of high-contact care for R2 on 11/5/24. R3 was on EBP due to wounds and colonized bacteria in R3's urine. Staff did not don the appropriate PPE during the provision of high-contact care for R3 on 11/5/24. Findings include: The facility's Infection Prevention and Control Program, revised 7/23/2024, indicates: .4. Standard Precautions: a) All staff shall assume that all residents are potentially infected or colonized with an organism that could be transmitted during the course of providing resident care. b) Hand hygiene shall be performed in accordance with our facility's established hand hygiene procedures. c) All staff shall use personal protective equipment (PPE) according to established facility policy governing PPE. 1. On 11/5/24 at 11:00 AM, Surveyor observed Certified Nursing Assistant (CNA)-I enter R2's room to assist R2 with morning cares. CNA-I wore a face mask and gloves, but no gown. Surveyor noted a sign on R2's door that indicated R2 was on EBP. On 11/5/24 at 11:15 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-G who indicated R2 was on EBP due to urinary concerns which required staff to wear a mask, gloves, and a gown when they assisted R2 with hands-on care. LPN-G verified CNA-I did not wear a gown while assisting R2 with cares. On 11/5/24 at 11:30 AM, Surveyor interviewed R2 who had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R2 was not cognitively impaired. R2 verified CNA-I assisted R2 with personal cares. R2 indicated EBP were recommended when caring for R2. R2 indicated staff did not consistently wear PPE when they assisted R2 with care or emptied R2's urinal. On 11/5/24 at 11:40 AM, Surveyor and Minimum Data Set Coordinator (MDSC)-D reviewed the EBP signage on R2's door. MDSC-D indicated CNA-I should have worn a gown during cares with R2. On 11/5/24 at 11:50 AM, CNA-I approached Surveyor and indicated CNA-I should have worn a gown while assisting R2 with cares. 2. On 11/5/24 at 1:34 PM, Surveyor observed CNA-J enter R3's room. Surveyor noted an EBP sign on R3's door. During an interview with Surveyor, CNA-J indicated CNA-J assisted R3 into bed and emptied R3's commode. CNA-J indicated CNA-J did not wear a gown as required when a resident was on EBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/5/24 at 2:15 PM, Surveyor interviewed R3 who had a BIMS score of 14 out of 15 which indicated R3 was not cognitively impaired. R3 indicated R3 was on precautions due to wounds on R3's lower extremities and because R3 had colonized bacteria in R3's urine. R3 indicated staff did not consistently wear PPE when they assisted R3 with care. X0440