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	04/08/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43361 Based on staff and resident interview and record review, the facility did not ensure an allegation of abuse/neglect was reported to the State Agency (SA) in a timely manner for 1 resident (R) (R2) of 11 sampled residents. R2 and R2's family member reported an allegation of abuse/neglect to staff. The facility did not report the allegation to the SA. Findings include: The facility's Abuse, Neglect, and Exploitation policy, revised 7/15/22, indicates: IV. Possible indicators of abuse include, but are not limited to: 1. Resident, staff or family report of abuse .VII. Reporting Response: 1. Reporting of all alleged violations to the Administrator, State Agency, Adult Protective Services and to all other required agencies (e.g., law enforcement when applicable) within specified time frames. On 4/8/25, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] and had diagnoses including obesity, muscle weakness, anxiety, and depression. R2's Minimum Data Set (MDS) assessment, dated 3/7/25, had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated R2 was not cognitively impaired. On 4/8/25 at 9:30 AM, Surveyor interviewed R2 who indicated staff did not provide care on the weekend due to shift change. R2 indicated R2's call light was on for an hour. R2 was incontinent of urine and staff did not complete care until the PM shift arrived. R2 told Medication Technician (MT)-C about the incident on Monday (4/7/25). R2 did not want to share the name of the staff who did not provide care. On 4/8/25 at 10:32 AM, Surveyor interviewed MT-C who confirmed R2 informed MT-C of an incident that occurred with Certified Nursing Assistant (CNA)-F over the weekend. MT-C indicated MT-C reported R2's allegation to Social Worker (SW)-E on 4/7/25 and saw SW-E speak to R2 the same day. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/8/25 at 12:03 PM, Surveyor interviewed SW-E who confirmed MT-C spoke with SW-E on 4/7/25. SW-E indicated MT-C said CNA-F needed a break from working on the unit but did not inform SW-E of an incident between R2 and CNA-F. SW-E did not ask why MT-C thought CNA-F needed a break from the unit. SW-E indicated SW-E spoke with R2 on 4/7/25 about R2's future plans for placement but not about a concern that occurred over the weekend. On 4/8/25 at 12:27 PM, Surveyor interviewed SW-E about previous contact with R2's family. SW-E indicated R2's family member left a voicemail but SW-E could not recall the date. SW-E indicated R2's family member was upset and irate and indicated staff told R2 that R2 could sit there and wait until R2 was tired. SW-E also indicated there was a concern about staff using a Hoyer lift versus an EZ stand lift. SW-E immediately contacted R2's family member and let them know that was unacceptable. SW-E contacted therapy who assessed R2 and changed R2 to an EZ stand lift for transfers. When asked if the comment from staff about R2 having to wait until R2 was tired was addressed, SW-E indicated it was not but should have been. On 4/8/25 at 1:25 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who was not aware of the allegation and confirmed the allegation should have been reported to the SA.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43361 Based on staff and resident interview and record review, the facility did not ensure all allegation of abuse/neglect was thoroughly investigated for 1 resident (R) (R2) of 11 sampled residents. The facility did not thoroughly investigate on allegation of abuse/neglect reported by R2 and R2's family member. Findings include: The facility's Abuse, Neglect, and Exploitation policy, revised 7/15/22, indicates: .IV. Possible indicators of abuse include, but are not limited to: 1. Resident, staff, or family report of abuse .V. Investigation of Alleged abuse, Neglect, and Exploitation: A. An immediate investigation is warranted when an allegation or suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. B. 1. Written procedures for investigations include: Identifying staff responsible for the investigation .4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegation .6. Providing complete and thorough documentation of the investigation. On 4/8/25, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] and had diagnoses including obesity, muscle weakness, anxiety, and depression. R2's Minimum Data Set (MDS) assessment, dated 3/7/25, had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated R2 was not cognitively impaired. R2 did not have an activated Power of Attorney for Healthcare (POAHC). On 4/8/25 at 9:30 AM, Surveyor interviewed R2 who indicated staff did not provide care over the previous weekend due to shift change. R2 indicated R2's call light was on for an hour and R2 was incontinent of urine. Staff did not complete care until the PM shift arrived. R2 told Medication Technician (MT)-C about the incident on Monday (4/7/25). R2 did not want to share the name of the staff who did not provide care. On 4/8/25 at 10:32 AM, Surveyor interviewed MT-C who confirmed R2 informed MT-C of an incident that occurred with Certified Nursing Assistant (CNA)-F over the weekend. MT-C reported R2's concern to Social Worker (SW)-E on 4/7/25 and saw SW-E speak with R2 that day. MT-C was not sure of the outcome and indicated it was not MT-C's business. On 4/8/25 at 12:03 PM, SW-E confirmed MT-C spoke with SW-E on 4/7/25. SW-E indicated MT-C said MT-C thought CNA-F needed a break from working on the unit but did not report an incident between R2 and CNA-F. SW-E did not ask why MT-C thought CNA-F needed a break and did not document the conversation. SW-E spoke to R2 on 4/7/25 about R2's future plans for placement but not about an incident that occurred over the weekend. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/8/25 at 12:27 PM, Surveyor interviewed SW-E about previous contact with R2's family. SW-E received a voicemail from R2's family member but could not recall the date. SW-E indicated R2's family member was upset and irate after staff told R2 that R2 could sit there and wait until R2 was tired. There was also a concern about staff using a Hoyer lift versus an EZ stand lift. SW-E immediately contacted R2's family member and let them know that was unacceptable. SW-E contacted therapy who assessed R2 and changed R2 to an EZ stand lift for transfers. When asked if the comment from staff about R2 having to wait until R2 was tired was addressed, SW-E indicated it was not but should have been. SW-E indicated there was no documentation of the conversation with R2's family member or investigation for the family member's allegation. On 4/8/25 at 1:25 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who was not aware of the allegation of abuse/neglect and confirmed the allegation should have been thoroughly investigated.

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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 - Minimal harm or potential for 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** 40342 Based on staff interview and record review, the facility did not provide the necessary care and services to promote healing and/or prevent pressure injuries from developing for 1 resident (R) (R1) of 2 sampled residents. R1 was admitted to the facility with a pressure injury (PI) on the left heel. The facility did not complete accurate assessments of R1's left heel PI. Findings include: The facility's Pressure Injuries and Non Pressure Injuries policy, revised 7/20/22, indicates: The center will complete a comprehensive assessment to identify risk factors for the development of pressure injuries and put in place measures intended to achieve the goal of prevention of pressure injuries in our residents. For those residents admitted with, or who subsequently develop a pressure injury or impaired skin integrity, they will receive care, treatment, and services that seek to promote healing, prevent infection, and prevent further development of pressure injuries/impaired skin integrity .The staging of a pressure injury is consistent with the recommendations of the National Pressure Injury Advisory Panel (NPIAP) and the Resident Assessment Instrument (RAI) Manual, Section M .Stage 1 Pressure Injury: Intact skin with a localized area of non-blanchable erythema .Stage 4 Pressure Injury: Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage, or bone in the ulcer .Unstageable Pressure Injury: Full-thickness skin and tissue loss in which the extent of tissue damage with the ulcer cannot be confirmed because the wound bed is obscured by slough (non-viable tissue, usually tan and stringy) or eschar (dead tissue, usually black or brown) .2. Weekly: .b. Assess current wounds at least every seven days . On 4/8/25, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including diabetes mellitus, non-pressure chronic ulcer of bilateral lower legs, pressure injury of left heel (admitted with), chronic kidney disease, and unspecified dementia without behavioral disturbances. R1's Minimum Data Set (MDS) assessment, dated 2/20/25, stated R1's Brief Interview for Mental Status (BIMS) score was 4 out of 15 which indicated R1 had severe cognitive impairment. R1 had a Power of Attorney for Healthcare (POAHC) who was responsible for R1's healthcare decisions. R1 was transferred to a hospital on 3/18/25 and did not return to the facility. R1's medical record contained the following Pressure Injury Weekly Tracker assessments for R1's left heel PI: ~ A Pressure Injury Weekly Tracker, dated 2/14/25, indicated R1 had a stage 1 PI on the left heel that was present upon admission. The PI measured 1.2 centimeters (cm) (length) x 0.01 cm (width) with 100% skin tissue. R1 was being followed by a wound clinic provider. ~ A Pressure Injury Weekly Tracker, dated 2/21/25, indicated R1 had a stage 1 PI on the left heel that measured 1.2 cm x 0.01 cm with 50% skin tissue and 50% granulation tissue (pink-red tissue that fills an open wound as it heals). (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	~ A Pressure Injury Weekly Tracker, dated 3/13/25, indicated R1 had an unstageable PI that measured 4.5 cm x 3.5 cm x 0.01 cm (depth) with 50% granulation tissue. The assessment did not indicate what type of tissue was in the other 50% of the wound. On 4/8/25 at 2:04 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B. NHA-A indicated the facility noted discrepancies with completion of wound assessments and started an action plan. DON-B indicated the action plan included review and auditing of pending and completed wound assessments in the facility's electronic medical record system to ensure completion. DON-B indicated staff education was being completed and the facility had a plan for audits. DON-B indicated the first staff education meeting was on 4/8/25 at 6:00 AM. DON-B indicated the staff education meeting scheduled for 2:30 PM on 4/8/25 was canceled because State Surveyors entered the facility at 8:00 AM. On 4/8/25 at 2:41 PM, Surveyor interviewed DON-B who provided documentation of the facility's action plan. DON-B indicated a scheduling report from the electronic medical record system was reviewed daily to ensure wound assessments were completed. Incomplete wound assessments were listed on an audit tool to track and follow-up with nursing staff. DON-B did not indicate if the facility looked at the accuracy of completed assessments. On 4/8/25, Surveyor reviewed a wound clinic note, dated 2/18/25, that indicated R1 was seen in the wound clinic for a chronic left heel PI since 10/24/24. Notes indicated R1's left heel PI measured 4.6 cm x 3.7 cm x 0. 1 cm on 1/30/25 and measured 4.5 cm x 3.4 cm x 0.1 cm with 100% granulation tissue on 2/1/25. The notes indicated R1's wound continued to improve. On 4/8/25, Surveyor reviewed the facility's action plan which included an education sign-in sheet, dated 4/8/25, for the 6:00 AM staff education meeting. Topics listed on the sign-in sheet included: Skin pressure/non pressure ulcers, Point of Care (POC) (a program in the electronic medical record), alerts, and User Defined Assessments (UDAs). The sign-in sheet contained eight staff signatures and did not mention accuracy of assessments. On 4/8/25 at 3:00 PM, Surveyor interviewed DON-B who indicated there were no wound care certified nurses on staff at the facility. DON-B indicated the facility contracted with a wound care provider who came to the facility for weekly rounds. DON-B verified R1 did not see the wound care provider because R1 was followed by an outside wound care facility.

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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. 51044 Based on observation, staff interview, and record review, the facility did not establish and maintain an infection prevention and control program designed to prevent the development and transmission of communicable disease and infection for 3 residents (R) (R9, R6, and R5) of 7 residents observed during medication administration and the provision of care. During observations of medication administration for R9, R6, and R5, Medication Technician (MT)-C and Licensed Practical Nurse (LPN)-D did not complete appropriate hand hygiene. MT-C and LPN-D did not adhere to contact precautions during medication administration for R6 and R5. Findings include: The facility's Transmission-Based (Isolation) Precautions policy, dated 9/24/24, indicates: .Contact precautions refer to measures that are intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the resident or the resident's environment .c. Healthcare personnel caring for residents on contact precautions wear a gown and gloves for all interactions that may involve contact with the resident or potentially contaminated areas in the resident's environment. d. Donning personal protective equipment (PPE) upon room entry and discarding before exiting the room is done to contain pathogens, especially those that have been implicated in transmission through environmental contamination. Recommendations for PPE: .Contact: Gloves-Whenever touching the patient's intact skin or surfaces and articles in close proximity to the patient (e.g., medical equipment, bed rails). [NAME] gloves upon entry into the room or cubicle. Gowns-Whenever anticipating that clothing will have direct contact with the patient or potentially contaminated environmental surfaces or equipment in close proximity to the patient. [NAME] gown upon entry into the room or cubicle. The facility's Contact Precautions Signage indicates: Clean hands, including before entering and when leaving room; Put on gloves before room entry; Discard gloves before room exit; Put on gown before room entry; Discard gown before room exit; Do not wear the same gown and gloves for the care of more than one person. 1. On 4/8/25 at 9:17 AM, Surveyor observed medication administration for R9. Surveyor noted MT-C did not complete hand hygiene prior to preparing medication for R9, entering R9's room, administering R9's medication, or providing water. MT-C also did not complete hand hygiene after exiting R9's room. 2. On 4/8/25 at 9:30 AM, Surveyor observed medication administration for R6 who was on contact precautions. Surveyor noted MT-C did not complete hand hygiene prior to preparing medication for R6, entering R6's room, assisting R6 to a sitting position at the edge of the bed, or administering R6's medication. MT-C also did not complete hand hygiene after removing 2 plastic water cups and exiting the room. Surveyor also noted MT-C did not wear a gown prior to entering R6's room, assisting R6 to a sitting position, or administering R6's medication. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/8/25 at 9:37 AM, Surveyor interviewed MT-C regarding hand hygiene. MT-C verified MT-C did not complete hand hygiene prior to entering or exiting R6 and R9's rooms during medication administration. MT-C stated MT-C was not aware MT-C needed to wear a gown in R6's room. 3. On 4/8/25 at 9:38 AM, Surveyor observed medication administration for R5 who was on contact precautions. Surveyor noted Licensed Practical Nurse (LPN)-D did not complete appropriate hand hygiene after exiting R5's room. LPN-D removed soiled gloves, held the gloves in LPN-D's right hand, and completed hand hygiene with the soiled gloves and insulin pens in hand. LPN-D then disposed of the soiled gloves at the nurses' station, disposed of pen needles in a Sharps container, and put insulin pens in the medication cart. LPN-D did not complete hand hygiene after putting insulin pens in the cart. Surveyor also noted LPN-D did not don a gown prior to entering R5's room, lifting R5's shirt, and administering R5's insulin. On 4/8/25 at 9:44 AM, Surveyor interviewed LPN-D regarding hand hygiene. LPN-D indicated hand hygiene should be completed prior to preparing medication, entering a resident's room, and existing a resident's room. LPN-D indicated LPN-D should have disposed of gloves and completed hand hygiene. LPN-D was not aware LPN-D needed to wear a gown in R5's room. On 4/8/25 at 1:09 PM, Surveyor interview Director of Nursing (DON)-B regarding hand hygiene and PPE. DON-B indicated staff should complete hand hygiene prior to medication preparation and prior to entering and exiting residents' rooms. DON-B stated staff should follow the PPE directions on the door for a resident who is on precautions.