

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525405	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/15/2025
NAME OF PROVIDER OR SUPPLIER Waterfall Health of Wausau		STREET ADDRESS, CITY, STATE, ZIP CODE 1010 E Wausau Ave 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 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44863</p> <p>Based on observation, interview and record review, the facility did not ensure necessary care and services were provided to promote healing and/or prevent pressure injuries (PI) from worsening/developing for 1 of 3 residents (R1) reviewed for pressure injuries.</p> <p>The facility did not complete an admission skin assessment of R1's sacral wound.</p> <p>Findings include:</p> <p>R1 was an [AGE] year-old-female admitted to the facility on [DATE], with diagnoses including diabetes mellitus type 2, severe obesity, anxiety, pressure ulcer of sacral region stage 2, urinary tract infection (UTI), stroke on 11/01/24.</p> <p>R1's Minimum Data Set (MDS) assessment, completed on 11/20/24, confirmed a score of 99/15, indicating R1 was not able to complete the assessment. Staff assessment of R1's mental status indicated severe impairment.</p> <p>R1's entry MDS assessment confirmed R1 was at risk for developing pressure injuries and a stage 2 pressure ulcer was present.</p> <p>R1's care plan included the following:</p> <ul style="list-style-type: none"> -R1 has limited physical mobility and is non-weight bearing. -R1 has an alteration in nutritional status related to diagnoses of congestive heart failure, hyperlipidemia, hypertension, hypothyroidism, and osteopenia. -R1 has potential/actual impairment to skin integrity. <p>On 04/15/25, Surveyor reviewed R1's hospital discharge information, which stated R1 discharged with a stage 2 PI of the sacral region. No measurements noted.</p> <p>On 04/15/25, Surveyor reviewed an initial skin assessment completed on 11/14/24 indicating R1 had bruising, but did not identify R1's sacral wound.</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 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 04/15/25 at 1:49 PM, Surveyor interviewed Director of Nursing (DON) B. Surveyor indicated there was no comprehensive skin assessment completed upon R1's admission on 11/14/24, and was not completed until 11/16/24, where it was indicated R1 had a stage 2 sacral wound, which measured 0.2 cm x 3.0cm. No documentation found whether this PI had worsened or improved since admission on 11/14/24 due to lack of admission skin assessment. DON B confirmed she would expect a comprehensive skin assessment to be completed upon admission, however a Licensed Practical Nurse (LPN) completed a basic skin assessment on 11/14/24, which indicated bruising along forearms. A Registered Nurse (RN) completed a comprehensive assessment on 11/16/24. DON B stated R1 admitted from the hospital with a sacral wound Stage 2.</p>		