STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525405	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterfall Health of Wausau	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)
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. 44863 Based on observation, interview and record review, the facility did not provide the needed supervision to prevent accidents for 1 of 3 residents (R) R5, reviewed for accidents. Facility staff did not provide supervision while R5 was eating breakfast. Speech Therapy instructions and care plan indicated R5 required supervision to eat. This is evidenced by: Example 1 R5's progress notes indicated he had a coughing/choking episode while eating in his room, on 07/03/24. R5's care plan was updated on 07/03/24, to include: Aspiration Precautions: Alternate liquid and solid swallows. Sit upright (90 degrees) when eating and drinking either in bed or wheelchair. Diet: regular, regular consistency with thin liquids, finger foods as able. Adaptive equipment: inner lipped 3 compartment plate, Kennedy cup with lid, standard spoon with foam handle. Eating: Close supervision and assist with food. Do not leave alone with food in front of him. Speech therapy evaluated R5 on 07/11/24 and recommended close supervision while eating. On 07/31/24 at 8:30 AM, Surveyor observed Licensed Practical Nurse (LPN) D exit R5's room. Surveyor observed R5 in his bed, with head elevated approximately 90 degrees; there were no staff present in R5's room. R5 had his breakfast plate on his lap, which contained a cinnamon roll and cubed potatoes. R5 was finishing eating a banana and began eating the cinnamon roll on his plate. (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	On 07/31/24 at 8:40 AM, Surveyor observed Certified Nursing Assistant (CNA) E enter R5's room. CNA E observed R5 was eating without supervision and stated out loud, They gave him his plate? Surveyor interviewed CNA E. CNA E stated R5 is supposed to be monitored and assisted with eating. The nurse gave him his medications and I told her I would be in after she gave him his meds. She works part-time/occasional maybe she didn't know, maybe she thought I would be in right away. Therapy updates are communicated through a board, therapy posted on the board that he is to be monitored/assisted while eating. If a new CNA started, they would learn he needs assistance/supervision through training with another CNA. On 07/31/24 at 8:48 AM, Surveyor observed R5's tray was removed from room. Surveyor observed R5 lying flat on his back with heels elevated. On 07/31/24 at 9:24 AM, Surveyor interviewed LPN D. LPN D reported R5 is to be supervised/monitored with eating, but knew the CNA was coming to assist him. LPN D looked at R5's orders and noted an order for aspiration precautions, LPN D stated, If I failed, I'm sorry. On 07/31/24 at 12:00 PM, Surveyor interviewed Medical Director (MD) F. MD F reported aspiration precautions included supervision with eating and any recommendations made by speech therapy. MD F confirmed an individual could choke in seconds. On 07/31/24 at 4:10 PM, Surveyor interviewed Speech Language Pathologist (SLP) G. SLP G confirmed R5 was receiving speech therapy treatments. SLP G stated R5 required close supervision with eating, and this was recommended at the time of R5's evaluation on 07/11/24.

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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 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. 51095 Based on observation, interview and record review, the facility did not accurately assess pain to ensure pain management for 1 of 1 resident reviewed for pain (R22). R22's pain assessments were not accurate and R22's care plan was not individualized. This is evidenced by: The facility's policy titled, Pain- Clinical Protocol (March 2018) reads in part, The nursing staff will assess each individual for pain upon admission to the facility, at quarterly review, whenever there is a significant change in condition, and when there is onset of new pain or worsening of existing pain. The staff and physician will evaluate how pain is affecting mood, activities of daily living, and the resident's quality of life, as well as how the pain may be contributing to complications such as gait disturbances, social isolation, and falls. The physician will order appropriate non-pharmacologic and medication interventions to address the individual's pain. On 02/21/24, R22's pain assessment indicated R22 experienced a sharp, stabbing pain to groin prior to recent hospitalization . On 02/26/24, R22's Minimum Data Set (MDS) assessment was completed and indicated a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. The assessment read R22 received as needed (PRN) medication, did not receive non-medication interventions for pain, and pain intensity was an 8 on a rating scale of 0-10. On 05/23/24, R22's pain assessment indicated R22 experienced pain in his scalp and groin, rated at 8/10. On 05/28/24, an annual MDS assessment was completed, indicating R22 received scheduled and PRN pain medication, pain frequency is rarely or not at all, R22's pain rating was 2/10, and there was no indication for staff assessment for pain. On 06/26/24, a pain evaluation for dementia/cognitively impaired residents indicated in part, that there is a pattern of frequency and a history of pain. No other recent pain assessments were provided that indicated location of pain. R22's physician's orders included Tylenol #3 and Tylenol Extra strength PRN. Non-pharmalogical interventions were not ordered. R22 does not have scheduled pain medications. On 07/1/24 through 07/29/24, in the Medication Administration Record (MAR) staff documented R22's daily pain. R22 rated his pain between 4 (moderate pain) up to a 9 (severe pain) on 15 of the past 29 days. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/1/24 through 07/29/24, in the Medication Administration Record (MAR) staff documented R22's pain when administering R22's PRN Tylenol #3. R22's pain was a 4 or greater on 22 of the past 29 days. R22's care plan reads in part, The resident has pain and/or receiving pain medications- has migraines. Nursing care plan indicates: -The resident will verbalize adequate relief of pain or ability to cope with incompletely relieved pain through the review date. -Administer analgesics per orders. -Monitor/document for side effects of pain medication. Observe for constipation; new onset or increased agitation, restlessness, confusion, hallucinations, dysphoria; nausea; vomiting; dizziness and falls. Report occurrences to the physician. -Monitor/record/report to Nurse resident complaints of pain or requests for pain treatment. -Notify physician if interventions are unsuccessful or if current complaint is a significant change from residents past experience of pain. On 07/30/24 at 10:48 AM, Surveyor interviewed R22. R22 reported at times his leg pain is up to a 10 (on pain scale 1-10). R22 reported that his back pain limits him being up out of bed. R22 stated he takes a little pill if the pain is really bad and it helps a little. They won't give me anything stronger. R22 reported he is not able to get out of bed for any length of time (more than an hour or 2) in any chair or his wheelchair. R22 reported he has had pain all over really and waved to his lower half of his body and has had pain since he came to facility 2 years ago after having blood clots in his legs. R22 had his eyes shut and laid on his left side for most of the interview. R22 demonstrated he can reposition himself, when Surveyor asked. On 07/30/24 at 2:00 PM, Surveyor observed R22 was still in bed. R22 reported he did not want to get out of bed because his back would hurt in his wheelchair. When asked if any other chair was attempted, like a recliner, R22 stated it hurts if he's out of bed in any chair. On 07/31/24 at 8:43 AM, Surveyor interviewed Certified Nursing Assistant (CNA) H, who reported R22 has not gotten out of bed during day shift for past 2 weeks due to his anxiety related to his suprapubic catheter leaking. CNA H stated if he's up in his wheelchair for any length of time he does complain of back pain and wants to get back in bed. He went on a fishing trip a few weeks ago and then he said his back really hurt. On 07/31/24 at 9:02 AM, Surveyor interviewed R22 and discussed rating his pain. R22 stated he will rate it when it's really bad and when I ask for something. R22 reported they do offer to get me out of bed. If I do get up it's only a couple of hours before my back starts to hurt. R22 denied his suprapubic catheter leaking. They just fixed it, so it's better now. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/31/24 at 9:18 AM, Surveyor observed R22 asked Licensed Practical Nurse (LPN) D for pain medication. LPN D reported, I can't give you anything yet. I'll come back when I can. LPN D then left the room. Surveyor asked if R22 rated his pain for her. LPN D stated, I am going to do that, and went back in to ask R22 to rate his pain. R22 rated his pain at a 5/10 and that it was in his legs and knee. Surveyor heard him state, It's all over really. LPN D then offered him Extra Strength Tylenol because it was too early to give him another dose of his Tylenol #3. R22 stated, That doesn't help, and requested his Tylenol #3. LPN D reported to Surveyor she tried getting his Tylenol #3 scheduled at least in the morning but the doctor wouldn't change it. LPN does not know why the doctor wouldn't do a scheduled pain med and she reported R22 does have pain most days. When asked if there are any other interventions for his pain, LPN D reported, Yes, I just offered him the regular Tylenol, but he doesn't take it. LPN D looked in chart and told R22 he could have his next dose of Tylenol #3 at 10:30 AM. Surveyor was unable to identify if facility reassessed R22's pain as his back/body pain was not identified in record. On 08/01/24 at 7:49 AM, Surveyor interviewed Director of Nursing (DON) B who stated the expectations for a resident experiencing pain is that the facility staff monitor the resident's pain and address it every shift. When asked what the risk is to the resident with pain if a comprehensive assessment is not complete, DON B replied they would have unmet pain needs. Surveyor showed DON B prior assessments completed in R22's medical record. DON agreed that R22's assessments did not indicate where pain was located. That is something we have to get changed. When discussing R22's pain specifically to his back pain and how it may limit his activities of daily living, DON B stated, His back pain does get worse when he is up in his chair.

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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. 49353 Based on observation, record review and interview, the facility did not implement enhanced barrier precautions consistent with current infection control standards of practice for 1 resident (R) reviewed on enhanced barrier precautions (R7). This is evidenced by: Surveyor reviewed the facility policy title, Enhanced Barrier Precautions, dated 03/25/24. The policy in part states: Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of Multidrug-resistant Organisms (MDROs) that employs targeted gown and gloves use during high-contact resident care activities that include: -Providing hygiene care -Changing briefs or assisting with toileting EBP should be used for the duration of the affected resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk. Surveyor reviewed R7's record and noted: 07/02/24 - Kennedy terminal ulcer, stage 2, sacrum, in-house acquired, new (7/1/24), staged by hospice. On 07/30/24 at 10:21 AM, Surveyor observed a yellow sign on R7's door alerting EBP was required. A PPE cart was stationed to the right of the door with hand sanitizer, disposable gloves, and disposable gowns. Surveyor observed Certified Nursing Assistant (CNAs) approaching R7's door holding washcloths and other personal care items. Surveyor asked what cares were going to be completed with R7. CNA C stated personal cares and repositioning. Surveyor observed CNA C complete hand hygiene and don gloves. No gown was donned. CNA C entered R7's room and performed personal cares following infection control standards but did not don gown at any point as required by the EBP signage on R7's door. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/30/24 at 10:42 AM, Surveyor interviewed CNA C regarding EBP precautions for R7. CNA C stated that R7 had a wound on his bottom, so that meant staff had to use EBP. Surveyor asked CNA C what EBP precautions included. CNA C stated that all the standard precautions plus using a gown. CNA C then stated, I messed up, didn't I? I should have worn a gown. CNA C then stated that she thought the nurse had told her EBP precautions were no longer needed during morning report. Surveyor asked CNA Z how staff know when a resident is placed on EBP. CNA C stated that staff are informed during morning shift report and a sign is placed on the resident's door. Surveyor asked CNA C what the facility's procedure was for removing EBP. CNA C stated that the Director of Nursing (DON) or the Assistant Director of Nursing (ADON) would inform the nurse and the sign would be removed. Surveyor asked CNA C what practice would be followed if seeing a EBP signage on a resident's door, but unsure if it is correct. CNA C stated that she should follow the EBP precautions. On 08/01/24 at 7:15 AM, Surveyor interviewed DON B regarding EBP policy and procedures. DON B stated that either the DON or ADON is responsible for determining when EBP precautions are needed, placing sign on door, and informing the floor nurse of the change. DON B stated that no orders are documented for EBP, but that the floor nurses are expected to relay EBP changes to all other nursing staff during morning report. Surveyor asked DON B about R7's EBP. DON B stated that EBP was removed the previous week after the wound on the sacrum had closed but was reinstated over the weekend after the wound opened again. DON B stated this information must not have been passed on to the nursing staff on Monday. DON B stated that CNA C should have followed EBP and used a gown while performing personal hygiene cares as the sign was posted on R7's door.