

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525611	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2025
NAME OF PROVIDER OR SUPPLIER Portage Cty Hlth Care Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 825 Whiting 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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>47248</p> <p>Based on staff interview and record review, the facility did not report an allegation of abuse to the State Agency (SA) for 1 resident (R) (R2) of 1 sampled resident.</p> <p>On 12/13/24, R2 complained of arm pain during cares and indicated a staff was bruising R2. Staff discovered 2 round bruises on the back of R2's right arm and a reddened area on R2's right elbow. The facility did not report the potential allegation of abuse and injuries of unknown origin the SA in a timely manner.</p> <p>Findings include:</p> <p>The facility's undated Abuse, Neglect, Mistreatment and Misappropriation of Resident Property policy indicates: It is the policy of the facility to encourage and support all residents, staff, families, visitors, volunteers and resident representatives in reporting any suspected acts of abuse, neglect, mistreatment, exploitation, or misappropriation of property .Reporting and Response: It is the policy of this facility that abuse allegations .including injuries of unknown origin are reported per federal and state law .Injuries of unknown origin: An injury should be classified as an injury of unknown source when both of the following conditions are met: The source of the injury was not observed by any person or the source of the injury could not be explained by the resident: The injury is suspicious because of the extent of the injury or the location or the number of injuries observed at one particular point in time or the incidence of injuries over time .The facility will ensure that all alleged violation involving abuse .are reported immediately, but not later than 2 hours after the allegation is made if the events that cause the allegation involve abuse or result in serious bodily injury or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the Administrator of the facility and to other officials (including the State Survey Agency and Adult Protective Services where state law provide for jurisdiction in long term care facilities) .</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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/12/25, Surveyor reviewed a facility-reported incident (FRI) for a potential allegation of abuse and injuries of unknown origin that were reported to staff on 12/13/24. The facility's initial report was not submitted to the SA until 12/15/24. The FRI indicated R2 complained of arm pain during cares on 12/13/24 that included a transfer and repositioning. Staff noted 2 round bruises that measured .7 centimeters (cm) x .7 cm and a reddened area that measured 4 cm x 2 cm on R2's right elbow. R2 could not provide a consistent explanation of how the bruises occurred. R2 first stated to Registered Nurse (RN)-D, He is bruising me. RN-D interviewed R2 again later in the shift and R2 indicated R2 might have bumped R2's arm on the wheelchair tray. On 12/14/24, R2 indicated to several staff that R2 did not know where the bruises came from. R2 became upset when R2 was unable to remember what occurred.</p> <p>On 2/12/25, Surveyor reviewed R2's medical record. R2 had diagnoses including chronic obstructive pulmonary disease (COPD), ulcer of esophagus with bleeding, and history of falling. R2's Minimum Data set (MDS) assessment, dated 12/29/24, had a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated R2 had moderate cognitive impairment. R2 was R2's own healthcare decision maker.</p> <p>On 2/12/25 at 8:35 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated the incident was originally documented on a grievance form on 12/13/24 and an investigation was conducted through 12/14/24. NHA-A indicated NHA-A did not believe R2's statement was an allegation of abuse and conducted a grievance investigation for an injury of unknown origin. NHA-A indicated when NHA-A arrived at the facility on 12/15/24, NHA-A spoke to R2 and Director of Nursing (DON)-B and was confident that no abuse occurred. NHA-A indicated NHA-A and DON-B discussed R2's injuries of unknown origin and concluded the SA should be notified. NHA-A confirmed NHA-A was aware the initial report was not submitted timely and contacted the SA regarding why the report was submitted late. The facility did not complete abuse or reporting education following the incident.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>47248</p> <p>Based on staff interview and record review, the facility did not ensure a potential allegation of abuse and injuries of unknown origin were thoroughly investigated for 1 resident (R) (R2) of 1 sampled resident.</p> <p>On 12/13/24, R2 complained of arm pain during cares and indicated a staff was bruising R2. Staff discovered 2 round bruises on the back of R2's right arm and a reddened area on R2's right elbow. The facility did not thoroughly investigate the potential allegation of abuse and injuries of unknown origin.</p> <p>Findings include:</p> <p>The facility's undated Abuse, Neglect, Mistreatment and Misappropriation of Resident Property policy indicates: .Injuries of unknown origin: An injury should be classified as an injury of unknown source when both of the following conditions are met: The source of the injury was not observed by any person or the source of the injury could not be explained by the resident: The injury is suspicious because of the extent of the injury or the location or the number of injuries observed at one particular point in time or the incidence of injuries over time .Injuries of unknown origin must be immediately investigated to rule out abuse. Injuries may include but are not limited to, bruising of the inner thigh, chest, face and breast, bruises of an unusual size, multiple unexplained bruises, and/or bruising in an area not typically vulnerable to trauma .Protection: It is the policy of this facility that the resident will be protected from the alleged offender .Immediately upon receiving a report of alleged abuse, the Administrator or designee will coordinate delivery of appropriate medical and/or psychological care and attention. Ensuring safety and well-being for the vulnerable individual are of utmost priority. Safety, security, and support of the resident, their roommate if applicable, and other residents with the potential to be affected will be provided. This should include as appropriate: Procedures must be in place to provide the resident with a safe, protected environment during the investigation: .i. The alleged perpetrator will immediately be removed and the resident protected. Employees accused of alleged abuse will be immediately removed from the facility and will remain removed pending the results of a thorough investigation .</p> <p>On 2/12/25, Surveyor reviewed a facility-reported incident (FRI) regarding an incident involving R2 that occurred on the 12/13/24 PM shift. On 12/13/24, R2 complained of arm pain during cares that included a transfer and repositioning. Staff discovered 2 round bruises that measured .7 centimeters (cm) by .7 cm on the back of R2's right arm and a reddened area that measured 4 cm x 2 cm on R2's right elbow. The FRI indicated Certified Nursing Assistant (CNA)-E provided cares for R2 when R2 complained of right arm pain and bruising was noted. The FRI contained an interview with Registered Nurse (RN)-D who completed the initial assessment and interview with R2 which indicated R2 stated, He is bruising me. RN-D interviewed R2 again later in the shift and R2 indicated R2 might have bumped R2's arm on the wheelchair tray. R2 indicated to several staff on 12/14/24 that R2 did not know how the bruises occurred and became upset when R2 could not remember what occurred.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A progress note documented by Social Worker (SW)-F indicated SW-F called R2's family representative and notified them of the bruising. Documentation indicated R2 said, he caused it and then stated R2 thought R2 bumped R2's elbow. Surveyor noted the facility did not thoroughly investigate the allegation of abuse or injuries of unknown origin or protect R2 and other residents from abuse during the investigation. Surveyor also noted staff education was not completed.</p> <p>From 2/10/25 to 2/12/25, Surveyor reviewed R2's medical record. R2 had diagnoses including chronic obstructive pulmonary disease (COPD), ulcer of esophagus with bleeding, and history of falling. R2's Minimum Data Set (MDS) assessment, dated 12/29/24, had a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated R2 had moderate cognitive impairment. R2 was R2's healthcare decision maker.</p> <p>On 2/12/25 at 8:35 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated R2's injuries of unknown origin were documented on a grievance form on 12/13/24 and an investigation was conducted through 12/14/24. NHA-A indicated NHA-A did not believe there was an allegation of abuse or that R2's injuries of unknown origin were the result of abuse. NHA-A indicated when NHA-A arrived at the facility on 12/15/24, NHA-A spoke with R2 and Director of Nursing (DON)-B and was confident that no abuse occurred. NHA-A confirmed no staff members who cared for R2 on 12/13/24 were removed from resident care pending the results of the investigation. NHA-A verified R2 stated He is bruising me and CNA-E was the caregiver who provided care at the time of the incident. NHA-A indicated CNA-E handled the situation per the facility's policy and immediately notified RN-D to assess R2. NHA-A indicated due to those reasons and CNA-E's work ethic, NHA-A believed CNA-E would not intentionally cause injury to a resident and ruled out abuse as a cause of R2's injuries of unknown origin. NHA-A indicated despite the fact that CNA-E was an outstanding employee, CNA-E should have been placed on administrative leave or removed from resident care pending the results of the investigation. NHA-A also indicated education on the facility's abuse policy and procedure should be provided to all staff. NHA-A confirmed the facility's policy for abuse investigations should have been followed during the investigation.</p>		