STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020447	A. BUILDING: _____ B. WING _____	C 07/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH HAVEN	**2301 EAGLE SUMMIT STEVENS POINT, WI 54482**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments An investigation into 2 complaints was conducted at North Haven on 07/02/2024 with information gathered through 07/08/2024. As a result of this survey one deficiency was identified. One (1) of 2 complaints was substantiated. Census: 19	N 000		
N 388	83.35(3)(c) Implement, follow the individual service plan Implementation. The CBRF shall implement and follow the individual service plan as written. This Rule is not met as evidenced by: Based on record review and interviews the provider did not ensure a resident's (Resident 1's) written ISP (Individual Service Plan) was implemented and followed for 1 of 1 resident reviewed. Resident 1 had a wound on her/his coccyx that required wound care and dressing changes. Resident 1's ISP directed staff to notify Hospice when the resident's dressing was soiled or fell off. This intervention was not consistently implemented and/or followed. Findings include: On 07/03/2024, Surveyor reviewed Resident 1's medical record. The record indicated the resident was admitted to the facility on 02/07/2024 with diagnoses of non-operable left femur fracture, dementia, disorder of the coccyx and soft tissue. Additionally, the resident had a guardian and was receiving hospice services. A skin monitoring sheet for Resident 1 dated 03/05/2024 indicated,	N 388		

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

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N 388	Continued From page 1 "Wound located on coccyx area. Hospice aware and currently performing wound care." Resident 1's ISP dated 07/02/2024 indicated, Resident 1 required full assistance from staff for all ADLs (activities of daily living) was incontinent of bowel and bladder, non-ambulatory and confined to a bed. Additionally, the ISP stated, "Nursing Procedures: [Resident 1] is followed by Hospice...Hospice RN (Registered Nurse) will assess, cleanse, and dress wound each visit. Notify Hospice if dressing becomes soiled or comes off of wound...Hospice RN to assess wound and perform dressing changes every other day..." On 07/02/2024, Surveyor reviewed Resident 1's observation notes. A note dated, 06/16/2024 at 1:45 AM, indicated, "While changing [Resident 1], resident's bandages and gauze came off of lower back by bottom. The staff tried to call on call but didn't answer. Staff put bandage over the bed sore loosely just to cover the opening." On 07/02/2024 at 9:35 AM, Surveyor interviewed Caregiver F regarding Resident 1. Caregiver F indicated Resident 1 was a total assist, bed bound and frequently incontinent of bowel and bladder. Caregiver F stated, "[Resident 1] has a lot of liquid stools and [her/his] coccyx wound bandage gets soiled often. When [Resident 1's] bandage is soiled I change the bandage, put a new one on, and initial and date the bandage." Surveyor asked Caregiver F what Resident 1's ISP directed staff to do when the wound dressing becomes soiled or falls off. Surveyor and Caregiver F reviewed Resident 1's current ISP together and Caregiver F stated, "No one tells you what to do for it...I didn't know I was supposed to call hospice when the wound	N 388		

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N 388	Continued From page 2 bandage was soiled or falls off..." On 07/02/2024 at 3:00 PM, Surveyor interviewed Caregiver A regarding Resident 1. Caregiver A indicated, Resident 1 was non-ambulatory, incontinent of bowel and bladder and on frequent checks for repositioning and toileting. Caregiver A stated, "I worked the night shift on 06/15/2024 and was training with [Caregiver B]. [Caregiver B] and I checked on [Resident 1] around midnight. [Resident 1's] wound dressing fell off [her/his] buttocks. The wound was really deep, and full of feces and green pus. [Caregiver B] and I placed gauze over it to cover the wound and used paper tape to hold it in place...We continued to check and change [Resident 1] throughout the night." Surveyor questioned Caregiver A if s/he notified anyone when the coccyx wound dressing fell off. Caregiver A stated, "This was my second day working with the residents, I didn't call or notify anyone. We did report this to [Team Lead-D] on 06/16/2024 when [s/he] arrived at work for the day shift." Surveyor asked Caregiver A if s/he was aware of Resident 1's ISP regarding [Resident 1's] wound care needs and intervention when the dressing becomes soiled and/or falls off. Caregiver A stated, "I was given no direction on [Resident 1's] wound or what to do if the dressing falls off or becomes soiled...[Caregiver B] who was training me didn't know what to do either if the bandage fell off or was soiled." Surveyor questioned Caregiver B if s/he had access to Resident 1's ISP. Caregiver B stated, "Yes, but I didn't think to look at [Resident 1's] ISP." On 07/03/2024 at 2:40 PM, Surveyor interviewed Caregiver B regarding Resident 1. Caregiver B indicated Resident 1 was non-ambulatory and was frequently incontinent of bowel and bladder.	N 388		

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N 388	Continued From page 3	N 388		

Caregiver B stated, "I worked the night shift on 06/15/2024 and was training [Caregiver A]. During the early morning on 06/16/2024, [Caregiver A] and I were changing [Resident 1] and [Resident 1's] wound bandage on [her/his] buttocks area came off. The wound was full of pus, feces and had a foul odor. I attempted to call [Administrator C], but there was no answer and I did not leave a message. I tried calling [Team Lead-D] and [s/he] didn't answer. [Caregiver A] and I found a bandage and placed it over the wound opening." Surveyor then asked Caregiver B if s/he called hospice. Caregiver B stated, "I didn't think to call hospice, I should've." Surveyor then asked what staff were told to do if Resident 1's wound bandage becomes soiled or comes off. Caregiver B stated, "I don't know what to do if [Resident 1's] bandage comes off or is soiled." Surveyor questioned Caregiver B if s/he had access and reviewed Resident 1's ISP for direction. Caregiver B stated, "Yes, I was given access to ECP (an electronic health record) in May 2024, but I didn't think to look at Resident 1's ISP in ECP."

On 07/03/2024 at 1:15 PM, Surveyor interviewed Hospice RN-E regarding Resident 1. Hospice RN-E stated, "[Resident 1] has a significant stage 4, non-healing coccyx wound and is constantly having liquid stools. I've educated staff multiple times to call hospice if the dressing becomes soiled or falls off because we need to protect it from infection. I have to clean and pack the wound, apply wound gel, cover with a form dressing and secure with two adhesive dressings." Hospice RN-E verified there was no documented hospice visit or wound care visit on 06/16/2024. Hospice RN-E further verified no call was placed to hospice triage from the facility on 6/16/2024. Hospice RN-E stated, "We had no

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N 388	Continued From page 4	N 388		

calls from the facility on 06/16/2024. We have triage staff that answers and documents all calls. If the facility would've called, a hospice nurse would have responded within an hour to assess, provide wound care and reapply the dressing...On 06/17/2024, I came in around 4:00 PM, for my scheduled nursing visit and completed wound care for [Resident 1]. I do recall after a weekend in June 2024 [Resident 1's] coccyx wound dressing came off and staff placed a dressing over it, without notifying hospice."

On 07/03/2024, Surveyor reviewed hospice visit notes from 06/13/2024 through 06/21/2024. The notes revealed hospice completed wound care for Resident 1 on 06/15/2024, 06/17/2024, 06/19/2024 and 06/21/2024. There were no documented calls to hospice triage or visits from hospice on 06/16/2024 for wound care. The hospice visit note on 06/21/2024 indicated, "[Resident 1] was quiet and cooperative throughout visit and tolerated wound care well. Staff removed dressing and covered wound with an adhesive dressing due to it getting soiled. Reinforced they need to call hospice for dressing changes due to increased risk of further bacterial contamination and causing greater damage to the wound..."

On 07/08/2024 at 2:00 PM, Surveyor interviewed Administrator C regarding Resident 1. Administrator C verified staff should not be performing any wound care for Resident 1 and should notify Hospice right away when Resident 1's wound dressing is soiled or falls off. Administrator C verified the intervention for notifying hospice for wound care was a current intervention and should be followed by staff.

In conclusion, the provider did not ensure

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N 388	Continued From page 5 Resident 1's ISP intervention for nursing procedures was implemented and followed.	N 388		