Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009226	A. BUILDING: _____ B. WING _____	C 05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONE CREST RESIDENCE	**805 PARCHER ST WAUSAU, WI 54403**

(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 On 05/16/2024, Surveyor conducted a complaint investigation at Stone Crest Residence. Data collection continued through 05/22/2024. The complaint was unsubstantiated. One deficiency was identified. Census: 13	N 000		
N 386	83.35(3)(a) Comprehensive Individualized Service Plan Comprehensive individual service plan. Scope. Within 30 days after admission and based on the assessment under sub. (1), the CBRF shall develop a comprehensive individual service plan for each resident. The individual service plan shall include all of the following: 1. Identify the resident ' s needs and desired outcomes. 2. Identify the program services, frequency and approaches under s. HFS 83.38(1) the CBRF will provide. 3. Establish measurable goals with specific time limits for attainment. 4. Specify methods for delivering needed care and who is responsible for delivering the care. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1's Individual Service Plan (ISP) included all identified needs and desired outcomes. Findings include: The facility is licensed to care for up to 16	N 386		

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

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N 386	Continued From page 1 residents in the following client groups: Physically Disabled, Advanced Age, Terminally Ill, and Irreversible Dementia/Alzheimer's disease. On 04/02/2024, the Department received a complaint about staffing and training for falls. On 05/16/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 02/20/2024. Resident 1 expired on 03/14/2024. Resident 1 was assessed to be a fall risk. The provider ordered a pressure alarm on 02/22/2024. The pressure alarm arrived on 02/28/2024. The ISP, dated 02/20/2024, did not contain information about the use of a pressure alarm. On 05/22/2024 at approximately 10:51 AM, Surveyor interviewed Clinical Services Assistant (CSA) A via telephone. CSA A reported that Resident 1 was considered a "high fall risk" and Resident 1 had a pressure alarm in place. CSA A verified Resident 1's ISP was completed on 02/20/2024. CSA A stated that CSA A requested a pressure alarm be used for Resident 1, and the pressure alarm was ordered on 02/22/2024 and arrived on 02/28/2024. Surveyor asked CSA A if the pressure alarm was noted on Resident 1's ISP. CSA A confirmed that the pressure alarm was not noted on Resident 1's ISP. CSA A reported that Resident 1's ISP should have noted the use of a pressure alarm but it did not. The provider did not ensure Resident 1's pressure alarm was identified on the ISP.	N 386		