STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016736	A. BUILDING: _____ B. WING _____	C 12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIMROSE MEMORY CARE OF WAUSAU	7704 FRANCISCAN WAY WESTON, WI 54476

(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 12/05/2024, Surveyor conducted a complaint investigation at Primrose Memory Care of Wausau. Data collection continued through 12/09/2024. The complaint was substantiated. One deficiency was identified. Census: 23	N 000		
Y3244	50.09(1)(L) Care (1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to (l) Receive adequate and appropriate care within the capacity of the facility. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1 received adequate and appropriate care within the capacity of the facility.	Y3244		

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

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Y3244	Continued From page 1	Y3244		

Resident 1 experienced a fall after colliding with a caregiver. Resident 1 sustained injuries and later died.

Findings include:

The facility is licensed to provide services for up to 32 residents within the following client groups: advanced aged, irreversible dementia/Alzheimer's disease and terminally ill.

On 08/16/2024, the Department received a complaint alleging a caregiver caused a resident to fall on 05/25/2024. The provider reported a fall involving Resident 1 to the Department on 05/29/2025.

On 12/05/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 02/23/2024. According to Resident 1's individual service plan (ISP), dated 03/28/2024, Resident 1's vision was "normal" and hearing was "good" and Resident 1 was "ambulatory." According to observation notes (recorded by Caregiver F), dated 05/25/2024, "Resident is in the hospital after a fall around 1700 on [his/her] way to supper [sic] [s/he] was take [sic] by ambulance to [named hospital]." According to a "Universal Incident/Occurrence Report, Facts observed at scene," dated 05/25/2024, "resident was walking to supper [sic] aide was coming behind [him/her] with another resident in a wheelchair and we went to go around [him/her] cause [sic] [s/he] stepped to the left so staff went to the right when resident came back to the right and walk [sic] right in front of staff colliding with one another and resident went down landing right on the left side of [his/her] head." The "Universal Incident/Occurrence Report" noted, "Steps taken to prevent

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Y3244	Continued From page 2	Y3244		

recurrence - make sure staff is walking with [him/her] and be mindful that residents are out of the way to avoid collisions."

On 12/05/2024, Surveyor reviewed Caregiver F's record. Caregiver F was hired on 08/11/2023. According to the May 2024 schedule, Caregiver F worked on 05/25/2024 (2:00 PM to 10:00 PM). According to a "Universal Incident/Occurrence Report," dated 05/25/2024, Caregiver F was escorting a resident via wheelchair to the dining room and Caregiver F collided with Resident 1. Caregiver F was terminated on 05/31/2024.

On 12/05/2024 at approximately 1:00 PM, Surveyor interviewed Caregiver D. Surveyor asked Caregiver D about Resident 1's fall on 05/25/2024. Caregiver D reported that Caregiver F "was escorting a resident backwards in a wheelchair" and Caregiver F "bumped into [Resident 1]"; Resident 1 fell and later died at the hospital and Caregiver F was fired.

On 12/05/2024 at approximately 1:20 PM, Surveyor interviewed Caregiver G. Surveyor asked Caregiver G about Resident 1's fall on 05/25/2024. Caregiver G stated that Caregiver F was pushing Resident 2 in a wheelchair and Caregiver F "collided" with Resident 1 and Resident 1 fell. Caregiver G noted that Caregiver F no longer worked at the facility.

On 12/05/2024 at approximately 3:55 PM, Surveyor interviewed Director C. Surveyor asked Director C about Resident 1's fall on 05/25/2024. Director C reported, "[Resident 1] fell and was at the hospital and the family wanted to meet with us." Director C stated that Caregiver F was pushing Resident 2 in a wheelchair by the dining room and Resident 2's wheelchair "bumped" into

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Y3244	Continued From page 3 Resident 1. Director C noted, "[Resident 1's] fall was 'quite severe' and after the incident we met with [Caregiver F] and provided education." Director C indicated that management instructed Caregiver F to "be aware of your surroundings, be careful, slow down and walk at the pace of residents." On 12/05/024 at approximately 4:15 PM, Surveyor interviewed Executive Director (ED) A. Surveyor asked ED A about Resident 1's fall on 05/25/2024. ED A reported, "[Caregiver F] called me and told me [Resident 1] fell and hit his/her head. I advised [Caregiver F] to call 'E-Care' (in-house emergency response system) and then 'EMS' (Emergency Medical Services) if warranted." ED A stated that all Caregiver F said was that Resident 1 fell and hit his/her head and there was blood. ED A noted, "[Caregiver F] did not say how [Resident 1] fell." On 12/05/2024 at approximately 4:45 PM, Surveyor interviewed Caregiver E. Surveyor asked Caregiver E about Resident 1's fall on 05/25/2024. Caregiver E reported, "I was working a 16 hour shift and came in at 2:00 PM on 05/25/2024. Me [sic] and my fiance, [Caregiver H] (no longer at facility), were taking residents to the dining room around 4:30 PM. It was about 4:45 PM, I was bringing residents from the west side of the building and [Caregiver H] was bringing residents from the east side of the building; I heard [Caregiver H] screaming at [Caregiver F] to stop." Caregiver E stated that Caregiver F was pulling Resident 2 backwards in a wheelchair and Caregiver F "ran into" Resident 1. Caregiver E stated, "I heard a 'thud.' [Resident 1] was on the floor crying out in pain." Caregiver E noted, "[Caregiver F] was pulling [Resident 2] backwards; we are not supposed to pull residents	Y3244		

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Y3244	Continued From page 4	Y3244		

backwards; this was 100 percent preventable."

On 12/09/2024 at approximately 1:19 PM, Surveyor interviewed Director of Nursing (DON) B via telephone. Surveyor asked DON B about Resident 1's fall on 05/25/2024. DON B stated, "We had to piece it together." DON B reported that Caregiver F was not initially forthcoming with how the fall occurred. DON B stated, "We concluded that [Caregiver F] was wheeling a resident backwards when [s/he] collided with [Resident 1]." DON B shared that Caregiver F was terminated on or about 05/31/2024 for falsifying information about Resident 1's fall and for not following ambulation/transferring protocols and procedures.

On 12/09/2024 at approximately 4:00 PM, Surveyor interviewed ED A via telephone. ED A verified that Caregiver F was terminated on 05/31/2024 for initially lying about Resident 1's fall on 05/25/2024 and for not following protocols and procedures. ED A reported that Caregiver F admitted to walking backwards and "bumping" into Resident 1, causing Resident 1 to fall.

On 12/09/2024, Surveyor reviewed Resident 1's death certificate, dated 06/02/2024. The death certificate noted that the cause of death was due to "Complications of a complex cervical spine injury, (due to or as a consequence of a) Witnessed Fall."

The provider did not ensure Resident 1 received adequate and appropriate care within the capacity of the facility.