STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018302	A. BUILDING: _____ B. WING _____	C 02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PLACE AT RIB MOUNTAIN	149500 COUNTY ROAD NN WAUSAU, WI 54401

(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 02/29/2024, Surveyor conducted a complaint investigation at Wellington Place at Rib Mountain. Two deficiencies were identified. The complaint was substantiated. Census: 21	N 000		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure that each resident received their medications as the physician prescribed. This was discovered for 2 of 5 sampled residents. Findings include: On 02/07/2024, the department received a complaint alleging new staff did not know the residents and had made medication errors. On 02/29/2024. at 7:32 AM, Surveyor observed Caregiver D give Resident 1 his/her medications. Caregiver D stated that Resident 1's cephalexin (an antibiotic) had been ordered the day before yesterday and had finally come in. Caregiver D stated s/he did not know why, as	N 352		

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

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N 352	Continued From page 1	N 352		

s/he was off yesterday. Caregiver D stated the procedure is that only the manager, the care coordinator, and the regional nurse could put new orders in the system so any changes needed to be done by them. Caregiver D stated the care coordinator left 2 weeks ago so the unit coordinator can put orders in the system.

At approximately 12:15 PM, Surveyor compared the physician orders and the medication administration record (MAR) for Resident 1. Surveyor requested the original order of Resident 1's cephalexin from Manager A, as it was not in Resident 1's record. Manager A looked in several stacks of paper on his/her desk and stated there was a "bombardment of faxes" that afternoon. Manager A showed Surveyor a fax, dated 02/21/2024, that had been found in a stack of papers. The order read to give cephalexin four times a day for 7 days. Resident 1's MAR showed the first two doses were not given until the evening of 02/27/2024 and continued from there. Manager A stated there had been faxes and discussions back and forth and Unit Coordinator (UC) C would know more about the delay, as s/he took care of it. UC C told Surveyor this was not the order that was the subject of discussions, and it was a different order for Resident 1. The MAR showed that Resident 1 did not get the antibiotic from 02/21/2024 to 02/27/2024. There was a 6-day delay in getting this resident his/her antibiotic.

Surveyor requested to review the other orders on the 21st that were part of the "bombardment." Manager A submitted one for Resident 2 and stated there was actually only one. Manager A submitted a fax, dated 02/22/2024. The fax appeared to be sometime between 8:00 AM and 9:00 AM, as the time was cut off at the top. The

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N 352	Continued From page 2 signed physician order was to discontinue Resident 2's Seroquel (an antipsychotic) as this was replaced with Zyprexa (another antipsychotic). Surveyor reviewed Resident 2's MAR and the medication was given at 2:00 PM on 02/22/2024 to 02/26/2024. It was given for 5 days after it was discontinued. At 12:44 PM, Surveyor interviewed Director of Operations (DO) B. DO B stated physician orders can come several ways but it has to be a signed paper copy of an order. DO B stated the expectation was that the manager should be completing the order change the same day it is received. At 1:30 PM, Manager A indicated s/he had no explanation as to the delays in starting and discontinuing these medications for Resident 1 and Resident 2.	N 352		
N 441	83.39(3) Hand washing. Employees shall follow hand washing procedures according to centers for disease control and prevention standards. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure that all staff were hand washing according to the Centers for Disease Control and Prevention (CDC) guidelines and their own policy and procedure. This was discovered during the medication pass observation. Findings include: On 02/29/2024, Surveyor observed Caregiver D	N 441		

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N 441	Continued From page 3	N 441		

between 7:32 AM and 8:00 AM, passing medications to Resident 1, Resident 2, Resident 3, and Resident 4. Caregiver D was observed to change gloves in between each resident but at no time did s/he wash his/her hands. There was no hand sanitizer on the cart. During the observation, these four residents received oral medications in small cups, eye drops, nasal sprays, and inhalers, all without any hand washing. Caregiver D was observed to type on the computer and touch the cart in between residents.

At 7:32 AM, Surveyor observed as Caregiver D give Resident 1 several oral medications with gloves on. Caregiver D did not clean his/her hands after s/he took off his/her gloves.

At 7:42 AM, Surveyor observed as Caregiver D then put on new gloves but did not wash his/her hands. Caregiver D gave Resident 5 oral medications and two inhalers. Caregiver D did not clean his/her hands after taking off his/her gloves.

At 7:45 AM, Surveyor observed as Caregiver D put on new gloves but did not wash his/her hands. Caregiver D gave Resident 3 oral medications and Timolol eye drops, using the same gloves. Caregiver D did not wash his/her hands before administering the eye drops and Caregiver D did not clean his/her hands after taking off his/her gloves.

At 7:50 AM, Surveyor observed as Caregiver D put on new gloves but did not wash his/her hands. Caregiver D gave Resident 4 eye drops, a nasal inhaler, and oral medications, using the same gloves. Caregiver D did not wash his/her hands before giving the eye drops and did not clean his/her hands after taking off his/her gloves.

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N 441	Continued From page 4 At 8:30 AM, Surveyor interviewed Caregiver D. Caregiver D stated s/he knew about the need to sanitize his/her hands in between each residents but there was no hand sanitizer on the cart. Caregiver D then went to find some sanitizer. At 9:15 AM, Surveyor interviewed Caregiver E. Caregiver E stated the s/he washed or sanitized his/her hands before putting on, and after taking off, his/her gloves, and s/he does this with each resident. At 9:50 AM, Surveyor interviewed Unit Coordinator (UC) C. UC C stated his/her understanding was that staff are to wear gloves all the time during medication pass but they needed to be changed between residents. CU C stated staff are to wash or use hand sanitizer each time and especially before giving eye drops. According to information found on https://www.cdc.gov/handhygiene/providers/guideline.html, "The Core Infection Prevention and Control Practices for Safe Delivery on All Healthcare Settings recommendations of the Healthcare Infection Control Practices Advisory Committee (HICPAC)" includes the following recommendations for hand hygiene in healthcare settings: Health care personnel should use alcohol-based hand rub or wash with soap and water for the following clinical indications: - Immediately before touching a patient. - Before performing an aseptic task or... handling invasive medical devices. - Before moving from work on a soiled body site to a clean body site on the same patient. - After touching a patient or the patient's immediate environment. - After contact with blood, body fluids, or	N 441		

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N 441	Continued From page 5 contaminated surfaces. **Immediately after glove removal. On 02/29/2024 at 10:00 AM, Surveyor reviewed the provider's policy and procedure titled "Medication Administration." The procedure was last revised 06/12/2013. On page 5 of 9, under the subject of infection control, it directs staff: "Medication assistants must wash their hands with soap and water (for a minimum of 20 seconds) or used alcohol-based gel after every resident physical contact. After using gel for three (3) to five (5) times, hands should be washed with soap and water." The procedure goes on to highlight infection control practices when administering eye medication: "Hands must be washed with soap and water to avoid alcohol irritation to the resident." Caregiver D was observed not washing his/her hands according to the CDC guidelines and the providers own policies and procedures.	N 441		