STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525503	A. Building B. Wing	01/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Benedictine Manor of Wausau	1821 N 4th Ave Wausau, WI 54401

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)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51095 Based on interview and record review, the facility did not ensure that a resident (R) received treatment and care in accordance with professional standards of practice for 1 out of 18 residents sampled. (R321) R321 has a history of daily opiate use and constipation. The facility bowel protocol was not followed or a thorough GI assessment completed, causing actual harm to R321. R321 was hospitalized with severe pain and was admitted with a fecal impaction. Findings include: The facility's bowel protocol, reviewed on 11/18/24, includes, in part: Bowel and Bladder Management . Bowel: Constipation (If no bowel movement in > 48 hours; Perform steps sequentially) -Perform rectal check to determine if impaction is present - Encourage 2,000 ml daily fluid intake unless contraindicated -Consult Dietician for dietary recommendations -Sennoside 8.6 mg take 2 tablets by mouth at evening prn for 3 days -Bisacodyl suppository 10 mg per rectum daily prn for 3 days - Reattempt Sennoside or Bisacodyl if no results after 24 hours and notify provider - Fleets enema per rectum x1 if no results from suppository -Monitor and record results from treatment. Lipincott 2020 Critical Care: Assessing the abdomen Use sight, sound, and touch to assess your patient's abdomen for abnormalities. Assessing your patient's abdomen can provide critical information about his internal organs. Always follow this sequence: inspection, auscultation, percussion, and palpation. https://www.ncbi.nlm.nih.gov/books A digital rectal examination is mandatory as the first diagnostic evaluation to confirm the diagnosis of fecal impaction. R321 was admitted to the facility on [DATE] with the following pertinent diagnoses: chronic pain syndrome, constipation by delayed chronic transit, Raynaud's syndrome with gangrene, unspecified severe protein-calorie malnutrition. (continued on next page)

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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F 0684 Level of Harm - Actual harm Residents Affected - Few	The Minimum Data Set (MDS) dated [DATE] indicates R321 had a Brief Interview for Mental Status (BIMS) of 15 out of 15 which indicates R321 is cognitively intact. R321's MDS indicates R321 is dependent on toileting, hygiene, bed, and wheelchair transfers. MDS indicates frequently incontinent of bowel, no toileting program in place, and no bowel patterns. R321's Medication Administration Record (MAR) indicates the following orders: HYDROcodone-Acetaminophen Oral Tablet 7.5-325 MG (Hydrocodone-Acetaminophen) Give 1 tablet by mouth six times a day for pain Senna Oral Tablet 8.6 MG (Sennosides) Give 1 tablet by mouth every 12 hours as needed for constipation -Ordered on 12/10/2024 at 05:56 PM. No documentation that this was given. Dulcolax Suppository 10 MG (Bisacodyl) Insert 1 suppository rectally every 24 hours as needed for Bowel Care. Order on 12/02/2024 at 03:18 PM. No documentation this was given in December 2024. Fleet Oil Rectal Enema (Mineral Oil) Insert 1 application rectally as needed for constipation *use residents home supply in room* -Ordered on 12/21/2024 at 08:35 PM. On 01/06/25 at 12:02 PM, Surveyor interviewed R321 regarding his general care at the facility. R321 indicated that he was still in bed because he was recently hospitalized . R321 reported he is still weak and tired. R321 had been hospitalized on [DATE] due to a fecal impaction. R321 reported that at approximately 11:30 AM on 12/22/24, he had told Licensed Practical Nurse (LPN) O that he had intense rectal pain and needed something done. R321 indicated LPN O called the charge nurse who gave the direction to LPN O to observe him for the afternoon. R321 then explained to LPN O he had a history of fecal impaction, once resulting in a bowel perforation and he could not wait because the pain was unbearable. R321 reported that LPN O again called the charge nurse, and LPN O then told R321 she was waiting to hear from the nurse. R321 reported he then asked LPN O that he be sent to the hospital. When LPN O did not send him, R321 called 911 himself, shortly after 1:00 PM. R321 reported he went to the ER where it was discovered R321 had a fecal impaction. R321 reported he is unsure if the facility was aware that he had not had a bowel movement (BM) in several days. Medical record was reviewed; no documentation of abdominal pain prior to 12/22/24. On 1/08/25, Surveyor reviewed R321's bowel movement records which indicated that R321's last BM was 12/18/24 at 7:06 PM med BM. No BM recorded for the next 4 days 12/19/24 through 12/22/24. Surveyor reviewed R321's progress notes. -nursing note indicates in part on 12/21/24- GASTROINTESTINAL: Bowel Sounds are Present Bowel Sounds are Hypoactive -Active SX: constipation. No GI appliance(s) used No nutritional deficits observed. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	12/21/2024 20:36 Nursing -Note Text: HUCU message sent: Resident brought in his own supply of Fleet enemas that he says he uses if he has not had a BM in several days. May we have order for Fleet enema PRN? HUCU message received: OK to use the enema. Please update if no BM Resident is refusing enema at this time On 12/22/24- GASTROINTESTINAL: Bowel Sounds are Present Bowel Sounds are Active Active SX: constipation. No GI appliance(s) used Active SX: meal intolerance or PO intake less than 25%. Of note, R321 has a history of daily opiate use and constipation. Despite this history the facility failed to complete a thorough GI assessment including palpating the abdomen, rectal check and bowel sounds. There is no evidence the facility staff checked to see when R321 had his last BM. R321 had to call 911 on his own due to severe pain and was admitted with a fecal impaction. On 01/07/25 at 10:17 AM, Surveyor interviewed LPN O. When asked about interventions for residents who are experiencing constipation, LPN O reported she would follow the bowel protocol when a resident is symptomatic of constipation. When asked about R321's constipation, LPN O reported an enema order was obtained the day prior and the enema was given per R321's request on 12/22/24. LPN O stated, [R321] was screaming he wanted to go to the hospital, but I was in with another resident and before I got a chance to go back in by him, [R321] had already called 911 LPN O then notified DON via telephone. On 12/22/24 at 12:19 AM, documentation in the MAR shows Fleet Oil enema was given; no results reported or documented from administering the enema. No documentation found, or provided by facility, that the provider was notified that this was day 4 with no bowel movement or that the enema given on 12/22/24 failed to produce results of a BM for R321. On 1/08/25, Surveyor reviewed R321's hospital discharge summary, which indicates in part, R321 .who presents with abdominal pain and was admitted for fecal impaction. On admission, he had a large fecal mass palpable in the rectal vault. Imaging showed a 7.6 CM stool ball with surrounding inflammation .was evaluated by GI. He is a difficult situation secondary to chronic opiate use, chronic immobility, and medical noncompliance in the past. He was treated with as needed suppositories and enemas here which seemed to work. Patient was treated for a urinary tract infection (UTI) with Keflex. Raynaud's, chronic diastolic heart failure, and atrial fibrillation were managed with patient home regimen. His chronic pain from neuropathy/scleroderma was treated with his home hydrocodone PRN. While here, he requested this whenever it could be given. Opiate use is thought to be a contributing to his constipation issues. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	R321 was hospitalized and treated for fecal impaction on 12/22/24 through 1/3/25. On 01/08/25, Surveyor requested facility's bowel protocol and documentation of interventions done for R321's constipation prior to his hospitalization from Director of Nursing (DON) B. On 01/08/25 at 11:00 AM, Surveyor interviewed DON B, who provided documentation of a late entry completed on 01/08/25 by LPN O after Surveyor asked questions about R321's constipation. This late entry for 12/22/24 states, Writer performed abdominal assessment including listening to bowel sounds that were present in all four quadrants. Writer also performed rectal exam .informed resident stool was at anus. Writer encouraged resident to drink water and resident stated he would rather drink soda than water. Encouraged resident to use bathroom to defecate rather than laying in the bed and going in the depends. Resident refused to use bathroom. DON B provided documentation that staff education was provided to LPN O about proper and timely documentation. DON B verbalized that the interventions documented on the late entry were not in R321's records prior to Surveyor's request of bowel interventions performed for R321 as indicated by the facility's Bowel Protocol. DON B verbally agreed there was no evidence to indicate that R321's constipation was addressed or that the facility's Bowel Protocol was followed, resulting in R321 experiencing pain and requiring hospitalization for fecal impaction.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30570 Based on observation, interview and record review, the facility did not effectively monitor psychotropic medications to ensure residents are receiving the lowest possible effective dose. The facility practice had the potential to affect 1 of 5 residents reviewed for unnecessary medications (R19). This is evidenced by: Surveyor requested and reviewed the facility policy titled Psychoactive Medications dated as most recently reviewed on 12/2024. The policy in part read: Policy: It is the policy of this facility to maintain every resident's right to be free from the use of psychoactive medication. ~Psychoactive medications .are to be administered only when required to treat the residents' medical symptoms. ~No psychoactive medications will be utilized without .a diagnosed specific condition and will include the target behavior .with the goal of reducing the duration and/or dose of the medication. ~Monitor and track progress towards the therapeutic goal (s) . ~Perform gradual dose reductions (GDR) as per regulatory guidelines to find the optimal dose or to determine whether continued use of the medication is benefiting the resident. Tapering may be indicated when the resident's clinical condition has improved or stabilized, the underlying causes of the target symptoms have resolved and/or non-pharmacological interventions, including behavioral interventions, have been effective in reducing the symptoms. Surveyor reviewed R19's record and noted the following: R19's most recent quarterly Minimum Data Set (MDS) assessment completed 12/27/24, indicated resident understands, is understood and has severely impaired cognition. R19 has no mood or behavioral symptoms of verbal, physical or other behaviors. R19 has delusions and rejects care. R19's diagnoses include unspecified dementia-unspecified severity with behavioral disturbance, anxiety and dysthymic disorder (persistent depressive disorder). R19 takes antipsychotic, antianxiety and antidepressant medications. Has a gradual dose reduction been attempted: No. R19's annual MDS, dated [DATE], indicated resident understands, is understood and is cognitively intact. R19 has no mood or behavioral symptoms of verbal, physical or other behaviors. R19 has no delusions and does not reject care. R19's diagnoses include unspecified dementia-unspecified severity with behavioral disturbance, anxiety and dysthymic disorder (persistent depressive disorder). R19 takes antipsychotic and antidepressant medications. Has a gradual dose reduction been attempted: No. R19's Orders: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/01/24: Rexulti Oral Tablet 2 MG (Brexpiprazole) Give 1 tablet by mouth one time a day for Dementia with behavioral disturbances Surveyor reviewed summary of Rexulti medications since the facility's last recertification survey and noted: Rexulti: ~9/08/23-3/24/24 Dose: 1 mg oral QD, Diagnosis: unspecified dementia, unspecified severity with other behavioral disturbance ~3/25/24-4/01/24 Dose: 1.5 mg oral QD, Diagnosis: unspecified dementia, unspecified severity with other behavioral disturbance ~ 4/02/24 to present: Dose: 2 mg oral QD, Diagnosis: unspecified dementia, unspecified severity with other behavioral disturbance R19's care plan which transitioned to facility's new electronic record November 2024 included: Focus: Resident receives antipsychotic, and SSRI (selective serotonin reuptake inhibitors/antidepressant) medication related to dementia with behaviors. Goal: Resident will be prescribed the lowest effective dose of medication. Date Initiated: 11/21/24, Target date: 3/19/25. Interventions: ~Attempt a gradual dose reduction per facility protocol. ~Monitor for targeted behaviors r/t (related to) rexulti use physical aggression, verbal aggression. ~Monitor for target behaviors every shift: tearfulness, low mood. Care plan in facility's previous electronic record from previous recertification survey to 11/2024. The care plan had no visible dates for initiation or target dates. Resident has a history of accusatory/paranoid comments, refusing cares, meals and medications r/t dx of dysthymic disorder and undiagnosed personality disorder per husband. I have a HX (history) of experiencing anger/agitation related to my cognitive functioning deficits/memory issues r/t DX of Dementia, my cognitive deficit, decline in ADL ability As evidenced by: HX of persistent anger with self or others HX of delusional thoughts/verbal expressions (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	HX of unpleasant mood HX of verbalizations of anger over loss HX of verbalization of non-acceptance over change of status day, persons involved, and situations. Document behavior and potential causes. Resident has a history of resisting care (e.g., blood work, taking medications, ADL assistance). Surveyor reviewed R19's record in the facility's previous medical record (Matrix Care) from previous recertification survey and the facility's current medical record (Point Click Care) and found no notes showing R19 had targeted behavioral concerns. Surveyor reviewed Consultant Pharmacist Recommendation to Physician reports and noted the following: ~12/22/24: Federal guidelines state antipsychotic drugs should have an attempt at gradual dose reduction (GDR) twice per year for the first year in 2 different quarters with a least 1 month between attempts, then annually thereafter. This resident has been taking Rexulti 2 mg QD (every day) since 3/04/24 without a GDR. Could we attempt a dose reduction at this time to perhaps Rexulti 1 mg QD to verify this resident is on the lowest possible dose? if not, please indicate response below: Response signed by physician 1/07/25: Reduce the dose of Rexulti to 1 mg po (orally) QD (every day). 3/18/24: Federal guidelines state antipsychotic drugs should have an attempt at gradual dose reduction (GDR) twice per year for the first year in 2 different quarters with a least 1 month between attempts, then annually thereafter. This resident has been taking Rexulti 1 mg since 9/8/23 without a GDR. Could we attempt a dose reduction at this time to perhaps Rexulti 0.5 mg QD to verify this resident is on the lowest possible dose? If not, please indicate response below: Response from physician: Box checked: Use in accordance with relevant current standards of practice for psychiatric disorder (i.e.: schizophrenia, delusional behavior, bipolar, atypical psychosis in absence of dementia, huntingtons, mania) All options require clinical rationale for continuing by physician stated below . Physician/Prescriber Response Contraindicated increase 3/25/24 r/t (related to) increased agitation/restlessness (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Although the physician noted R19 with increased agitation/restlessness, R19's record showed no targeted behaviors of physical/verbal aggression. Surveyor observed R19 throughout survey in her room eating meals, watching television and interacting with staff. No behavioral or mood concerns were observed. On 1/07/25 at 8:03 AM, Surveyor spoke with Certified Nursing Assistant (CNA) E regarding R19's routine, preferences, and behavioral concerns. CNA E expressed R19's cares had been done already this morning and are done when she wakes up which is sometimes day shift and sometimes night shift. R19 is given the choice if she wants to get up out of bed. Most often R19 prefers to stay in bed and eats her meals in bed in her room. R19 enjoys certain television shows that are turned on her TV. R19 is also offered a busy box in bed for her to manipulate. Sometimes R19 wants it and sometimes not. R19 does not show indicators of pain and is good as far as behaviors when her routine is kept. On 1/08/25 at 10:52 AM, Surveyor spoke with Registered Nurse (RN) F who has worked at the facility several years and is familiar with R19 regarding R19's behavioral concerns. RN F indicated R19 has no recent mood or behavioral concerns. R19 has history years ago of intense behaviors. R19 will occasionally get a little agitated with cares which is very sporadic. R19 is not combative and does not appear in any distress. On 1/08/24 at 11:02 AM, Surveyor spoke with Director of Nursing (DON) B, Regional Administrator Lead (RAL) G and Clinical Resource Registered Nurse (CRRN) H about the facility's process for monitoring effectiveness of psychoactive medications and ensuring residents are on the lowest possible effective dose of medications when treating behavioral disturbance for residents with dementia; specifically, R19. DON B explained nurses chart daily on behaviors. If behaviors occur nurses do a corresponding note. The facility transitioned from one medical record system to another during change of ownership in November 2024. R19 has a history of verbal and physical aggression towards staff. R19 is treated with Rexulti for her behaviors associated with dementia. R19 had a care plan in the previous medical record for her targeted behaviors of aggression that was transitioned to point click care in November 2024. Both record systems were checked and R19 has not demonstrated targeted behaviors. The facility has a behavioral committee that looks at residents on psych medications and review pharmacist recommendations for GDRs. Surveyor asked DON B for clinical rationale for increasing R19's Rexulti (antipsychotic medications) when no targeted behaviors were occurring. DON B expressed there was one occasion R19 attempted to crawl out of bed. The team thought she may have had increased restlessness when she attempted to crawl from bed thus her medication was increased. Surveyor asked DON B if the team considered R19's lack of targeted behaviors when the increases in the Rexulti occurred. DON B expressed there was no clinical rationale based on R19's targeted behaviors to increase her medication. DON B further expressed she would continue to check R19's record and provide surveyor with any information that would support the increase and lack of GDR if anything was found. RAL G expressed the facility is aware the process for monitoring residents on psychoactive medications needs improvement. The facility has not yet implemented a process improvement plan since acquisition of the facility in November 2024.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30570 Based on observation, record review and interview, the facility did not allow clean dishes sufficient time to air dry or store the clean dishes in a manner to prevent potential contamination. The facility practice has the potential to affect all 76 residents. This is evidenced by: The facility policy tilted Dishwashing and Ware Washing which was not dated was requested and received by Surveyor. The policy in part read: Objective: To ensure cleaning, sanitization and infection control in the dishwashing area to promote food safety, prevent contamination and minimize the risk of spreading infections. Washing (Mechanical or Manual): Dish Drying: ~Dishes, utensils and cookware will be allowed to air dry completely on clean, sanitized racks or drying shelves. Inverting Dishes: Inversion: All plates, bowls, cups and similar items will be inverted (placed upside down) during storage to prevent contamination from airborne particles and dust. On 1/07/25 at 9:55 AM, Surveyor observed Dietary Aide (DA) C doing dishes in the dish room. DA C was observed spraying dirty dishes and loading dishes to a dish rack. DA C removed her apron and gloves and performed hand hygiene. DA C donned a clean apron and gloves and proceeded to the clean dishes to stack the coffee cups and bowls on trays. The coffee cups and bowls were not completely air dried. The bowls were not inverted and placed on the racks to store. Surveyor observed the bowls to have standing water in the bottom of the bowls. Surveyor observed racks of bowls that were stacked below the rack DA C had placed the bowls just removed from the dish rack/dish machine. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Surveyor and DA C observed standing water in the bowls that had been stacked and not allowed sufficient time to air dry or inverted when stacked. Surveyor asked DA C to observe the coffee cups that had been removed from the dishwasher and not allowed to air dry before being stacked on trays in an inverted manner. Surveyor and DA C observed the coffee cups to have water that had not air dried in the bottom of the coffee cups. Surveyor asked DA C how long she has been in her position and if dish washing is part of her responsibilities. DA C expressed she has been on staff [AGE] years and doing breakfast dishes is part of her daily responsibilities. Surveyor asked DA C if the observed process of washing dishes, unloading immediately from dish machine and stacking to trays as observed by Surveyor is her normal process. DA C indicated the observed process is the way she does dishes each day for breakfast. Surveyor asked DA C if the observed standing water in the dishes may pose a risk for contamination. DA C responded the water in the dishes could grow mold and other bacteria and pose a risk for contamination. Following the observation Surveyor was joined by Dietary Supervisor (DS) D in the dish room. Surveyor spoke with DS D about the observation and the still remaining water in the bottom of the bowls that were not inverted and the slight water in the coffee cups that were not allowed to air dry. DS D instructed DA C on allowing more time for dishes to air dry and stacking the bowls in a different manner to invert and not allow for standing water. Surveyor asked DS D if the current manner of dish washing poses a risk for contamination of the presumed clean dishes. DS D responded she understood how the process and the water in the clean dishes could pose a risk for contamination. She will be changing the manner the dishes would be stacked and instructing staff to allow more time for the dishes to air dry.