STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525365	A. Building B. Wing	03/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Valley Community Village	25951 Circle View Lane Richland Center, WI 53581

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50698 Based on interview and record review, the facility did not ensure that in response to allegations of abuse, neglect, exploitation, or mistreatment, the alleged violations are thoroughly investigated for 1 of 8 residents (R2) reviewed for abuse. R2 reported to staff she was missing money. SS I (Social Services Director) initiated the investigation, but failed to interview other residents to ensure there were no other allegations or concerns. Evidenced by: The facility policy entitled, Abuse Investigation and Reporting, last revision date of 3/6/2024, states, in part; . For Abuse Investigation: Upon discovery of alleged violations involving mistreatment: neglect, exploitation, or abuse, including injuries of unknown source, and misappropriation of resident's property, immediately protect the resident and immediately report the incident to your supervisor who in turn needs to immediately contact the administrator or designee .Thorough investigation: Upon learning of an alleged incident and having protected the resident a thorough investigation focused on collecting information that corroborates or disproves the incident will immediately begin .Interview and obtain written statements from any witnesses including other residents .Interview and obtain statements from other residents .to determine if there are similar concerns . R2 was admitted to the facility on [DATE] with diagnoses including: Infection and inflammatory reaction due to internal right knee prosthesis, aftercare following joint replacement surgery, chronic atrial fibrillation (irregular heart rate that causes poor blood flow), depression, and chronic kidney disease. R2's Brief Interview for Mental Status (BIMS) score from R2's admission Minimum Data Set (MDS) is 10 out of 15, indicating R2's cognition is moderately impaired. Facility self-report to state agency, states, in part: .On 2/12/2025, Received concern from CNA staff that resident confirmed she was missing money. This writer presented to resident's room upon her return from an appointment. Explained why writer was there and resident confirmed she was missing money. Following a thorough search of the room/purse with R2's permission, we were unable to locate the money. R2 reported last seeing the money a couple of days ago. In speaking further with R2, she felt that someone had stolen the money. Due to not being able to locate the money and overall nature of the complaint an investigation was submitted .Upon speaking with the resident, she appeared shocked and couldn't quite understand why something like this would happen . (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525365	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/31/2025
NAME OF PROVIDER OR SUPPLIER Pine Valley Community Village		STREET ADDRESS, CITY, STATE, ZIP CODE 25951 Circle View Lane Richland Center, WI 53581	

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The last page of the supporting documents states in part: .Lastly, in good faith effort, despite there being no evidence to support any misconduct the facility will reimburse R2 with $42 . On 3/17/25 at 9:55 AM, Surveyor interviewed R2 and asked about the misappropriation allegation on 2/12/25. R2 stated she had $42 taken out of her purse a few weeks ago. R2 indicated she reported it to staff, the money wasn't found, and she started a trust account at the desk for her money. R2 stated she doesn't think the missing money got replaced yet, facility was supposed to reimburse her the $42. Surveyor asked R2 if anyone from the facility has given her an update on the status of the money or let her know when the $42 would be in her account. R2 stated, No, I haven't heard a word more about it. R2 stated to Surveyor she isn't happy with the follow up. On 3/17/25 at 10:20 AM, Surveyor interviewed SS I (Social Services Director) about the misappropriation allegation from 2/12/25 involving R2. SS I stated a CNA reported to staff, that R2 reported she was missing money. SS I interviewed R2 and R2 shared she was missing $42. SS I indicated with R2's permission, they searched her room and purse together and were unable to locate the money. SS I stated facility contacted law enforcement, updated R2's daughter, talked to R2 about starting a trust account at facility and R2 started one, interviewed staff who worked the days around the incident - 12 staff total. SS I indicated they did not interview other residents and did not provide staff education following the incident. On 3/17/25 at 10:30 AM, Surveyor interviewed BS J (Billing Specialist) about R2 being reimbursed the $42 from the misappropriation allegation on 2/12/25. BS J stated they haven't reimbursed the money yet, but she will be cutting a check at the end of the month from the emergency fund. BS J stated she thought the investigation was still ongoing. Of note, the facility submitted the full self-report with all of their investigation findings on 2/19/25 at 2:52 PM. On 3/17/25 at 10:50 AM, Surveyor reviewed the self-report and supporting documentation provided with the facility investigation. There is no mention or evidence of the facility interviewing any other residents besides R2 to determine if other residents have concerns with missing money or other items. There is also no mention of staff education being provided. On 3/17/25 at 5:10 PM, Surveyor interviewed NHA A (Nursing Home Administrator) regarding completing a thorough investigation for an allegation of misappropriation. NHA A indicated facility should have included other resident interviews.

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(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 - Immediate jeopardy to resident health or safety 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** 39713 Based on interview and record review, the facility failed to ensure that each resident receives treatment and care in accordance with professional standards of practice for 2 out of 8 total sampled Residents (R4 and R5). Staff failed to recognize a change of condition in R5 until the Nurse Practitioner (NP) assessed the patient. Facility staff did not assess and monitor R5's condition as ordered by the physician. R5 was not sent to the emergency room (ER) per the NP's directive until 22 hours later, by which time R5's condition had worsened, resulting in R5 being admitted to Hospital where R5 was diagnosed with Sepsis, Pneumonia, and Acute Respiratory Failure with Hypoxia. R5 passed away two days later at the hospital. R4 was reporting irregular heart rates when an on-call physician gave orders to transport to the emergency room if apical pulse was greater than 115, the facility did not assess R4 or monitor R4's pulse for the next ten hours. R4 presented with irregular heart rate of tachycardia (fast heart rate) and bradycardia (low heart rate) and the facility sent R4 to the hospital via taxi vs. a medical transport service. Facility failure to recognize an acute change in condition, failure to closely monitor and assess a Resident with an acute change in condition, and failure to send a resident experiencing a significant condition change to the emergency room via ambulance rather than taxi created a finding of Immediate Jeopardy that began on [DATE]. Surveyor notified NHA A (Nursing Home Administrator), DON B (Director of Nursing) of the Immediate Jeopardy on [DATE]. The Immediate Jeopardy was removed on [DATE]; however, the deficient practice continues at a scope/severity of a D (potential for more than minimal harm/pattern) as the facility continues to implement its action/corrective plan. This is evidenced by: The facility policy titled, Change of Condition, Resident, last revised [DATE], states in part . PURPOSE: To ensure timely assessment, documentation, RN (Registered Nurse) notification, physician notification, care planning, and resident/legal representative notification of significant change in the resident's physical, emotional, or psychological condition. POLICY: All staff members shall communicate any information about a resident's condition that could potentially indicate a significant change of condition to the resident's nurse. The nurse will gather data on the resident's condition and as appropriate, provide timely notification to the RN (Registered Nurse), if nurse is an LPN (Licensed Practical Nurse), the Physician/Medical provider, Resident of Legal Representative (Activated POA (Power of Attorney) or Legal Guardian). In the event that the RN is not available in-house, the RN on-call will be notified via phone for consultation. Other family members will be notified upon consent of the resident/legal representative. THE FOLLOWING ARE EXAMPLES OF CHANGES IN RESIDENT CONDITION: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	b. Changes in respiratory status including altered respiratory rate, oxygen saturation, breath sounds, or complaints of shortness of breath. k. Blood pressures that exceed the resident's established parameters or other symptomatic blood pressure variations. z. All infections/symptoms of infection. aa. Pain. New pain or changes in pain location, quality, intensity. PROCEDURE: a. All staff will report any observed or reported changes to the nurse caring for the resident, or the nurse supervisor/manager immediately. Should an MA (Medication Aide) be working on the household, they also should report changes of condition to the nurse and the process below will take place. The nurse can delegate tasks to the MA, within their scope/skill set, but the nurse is responsible for ensuring that appropriate care and assessment takes place./ b. The nurse will observe the resident, gathering subjective and objective data. Vital signs will be obtained /as appropriate for the condition. (Nurses are highly encouraged to use the AMDA (now known as PALTmed (Post-Acute and Long-Term Care Medical Association)) took. PROTOCOLS FOR PHYSICIAN NOTIFICATION, available at each nursing station to assist them in gathering the appropriate data before physician notification.) d. The nurse will notify the physician in a timely manner, documenting the notification, actions taken, and any new order received. Should an RN not be in house, this need not wait for RN consultation in emergency situations. *SPECIFIC SITUATIONS THAT INDICATE IMMEDIATE NEED FOR RN/MD NOTIFICATION: New onset of respiratory distress. NOTE: In the event that it is after clinic hours and the on-call MD cannot be reached within a reasonable time, the resident's primary MD should be contacted. If at any point the change of condition becomes emergent and the MD cannot be reached for orders, the nurse may elect to call the EMS (Emergency Medical Services) and notify the ER (emergency room) of the pending admission. h. Initially, changes in condition and related observations/assessments will be documented every shift in the nursing notes. Upon assessment of the nurse manager, documentation will continue at specified intervals until the problem resolves. Facility provided Surveyor with document from PALTmed, titled Acute Change of Condition in the Long-Term Care Setting, which states in part . Vital Signs: Report Immediately: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Systolic BP (blood pressure) >(greater) 210 mmHg (millimeters of mercury) Diastolic BP >115 mmHg Resting pulse >130 bpm (beats per minute) or >110 bpm and patient has dyspnea or palpitations Chest pain: New onset or recurrent, not relieved in 20 minutes by previously nitroglycerin x (times) 3. Accompanied by change in vital signs, diaphoresis, nausea, vomiting, shortness of breath. According to the Wisconsin Nurse Practice Act, N6.03(1), An R.N. (Registered Nurse) shall utilize the nursing process in the execution of general nursing procedures in the maintenance of health, prevention of illness or care of the ill. The nursing process consists of the steps of assessment, planning, intervention, and evaluation. This standard is met through performance of each of the following steps of the nursing process: (a) Assessment. Assessment is the systematic and continual collection and analysis of data about the health status of a patient culminating in the formulation of a nursing diagnosis. (b) Planning. Planning is developing a nursing plan of care for a patient which includes goals and priorities derived from the nursing diagnosis. (c) Intervention. Intervention is the nursing action to implement the plan of care by directly administering care or by directing and supervising nursing acts delegated to L.P.N.s (Licensed Practical Nurse) or less skilled assistants. (d) Evaluation. Evaluation is the determination of a patient's progress or lack of progress toward goal achievement which may lead to modification of the nursing diagnosis. According to N6.04(1), In the performance of acts in basic patient situations, the L.P.N. shall, under the general supervision of an R.N. or the direction of a provider . (b) Provide basic nursing care. (c) Record nursing care given and report to the appropriate person changes in the condition of a patient . (e) Perform the following other acts when applicable: 1. Assist with the collection of data . Example 1 R5 was admitted to the facility on [DATE] with an Activated Healthcare Power of Attorney (AHCPOA). R5's diagnoses include in part . Diabetes Mellitus, Type 2, muscle wasting and atrophy, dementia, post traumatic stress disorder (PTSD), tremor, acute kidney failure, chronic kidney disease stage 4, peripheral vascular disease (PVD). R5's Quarterly MDS with an Assessment Reference Date (ARD) of [DATE] states in part . Brief Interview of Mental Status (BIMS) 10, indicating R5 had moderate cognitive impairment. Section E0100 indicates R5 has delusions but no other behaviors. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Nursing Progress Note from [DATE] at 16:32 (4:32 PM) states, Spoke with Dr. (Doctor) regarding R5's back pain at 1205 and new orders given: -Lidocaine 4% adhesive patch as needed for back pain. Remove after 12 hours. -Mylanta-30mL (milliliters) by mouth every 4 hours as needed for GI (Gastrointestinal) upset. Suggested trying Mylanta because sometimes heartburn can cause mid-back pain. Orders faxed to pharmacy after they were received. Of Note: No vitals, or any type to assessment documented at this time. Of Note: There are no further assessments or vitals taken for R5 between [DATE] at 4:32 PM and [DATE] at 1:32 PM. Nursing Progress note from [DATE] at 13:32 (1:32 PM) states, R5 complained of mid-back pain this morning when he was getting up out of bed. Lidocaine patch placed and Mylanta given, and Tylenol given. Later stated that it helped. Followed up with him again at lunch time and stated that he had a little bit of pain but, not too bad. Did not want anything more for pain. At 1330 writer called to room by CNA (Certified Nursing Assistant). R1 was sitting on the toilet and complaining of back pain again. He stated that it was terrible. When asked to rate his pain with a number he stated ,d+[DATE]. Writer asked him if he would like to be seen in ER (emergency room) today or if he would like to try to get an appointment tomorrow for someone to look at his back. He stated he would like to wait for an appointment tomorrow. I let him know that I would call his son and call the on-call physician. Nursing Progress Note from [DATE] at 1338 (1:38 PM) states, attempted to call HCPOA (Healthcare Power of Attorney) but he did not answer. On [DATE] at 13:56 (1:56 PM), R5's documented VS (vital signs) are, pain ,d+[DATE] (10 out of 10), 02 sat (oxygen saturation) 89% (percent), R (respirations) 20, pulse 104, T (temperature) 98.2, BP ,d+[DATE]. Nursing Progress Note from [DATE] at 1414 (2:14 PM) states, On-call MD (Medical Doctor) called and updated, after explaining the situations. She asked for a set of vitals. While obtaining vital signs, R5 and I discussed about the ER or appointment tomorrow again and he still stated that he would prefer to have an appointment tomorrow vs the ER. Vitals within his normal limits except O2 sat was running ,d+[DATE]%. He does appear to be a little short of breath, lungs sound clear. He denies any feelings of SOB (shortness of breath). Looking back in his history it appears that his O2 sats run ,d+[DATE]%. HPOA returned call and we discussed options and R5's preference to wait for an appointment tomorrow. HPOA stated that he would like us to monitor him for a few hours and if it gets any worse that he would like him evaluated in the ER as he is concerned about his kidneys as R5 does have kidney failure and is waiting for a nephrology consult through University of Wisconsin. Called MD back to update her on vitals and discussion with HPOA. Reviewed labs that were done [DATE]. She is ok with HPOA's decision to monitor for a few hours and if he is getting worse to have him evaluated in the ER. There is no documented evidence that staff monitored R5 over the next few hours. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Progress Note from [DATE] at 2138 (9:38 PM) states, R5 calling out a lot most of shift, saying Help me, help me . Staff go in and ask what he needs help with, and resident states I don't know. He does not seem to be more content if there is someone sitting in his room with him. Resident given Tylenol when able to help keep comfortable throughout shift. Resident is calm and quiet and resting in his bed at this time. (Med Tech) Of Note: The above note was written by a Medication Aide (MA). R5 has no assessments or vitals completed between [DATE] at 1:56 PM and [DATE] at 11:34 AM (21.5 hours). Nursing Progress Note from [DATE] at 11:34 AM states, in this morning when resident was in the dining room this writer asked how he is doing and he states, fine denied pain, denied back pain. After breakfast this writer did VS: BP ,d+[DATE], P94, O2 ,d+[DATE] at RA, R 98.3. Resident denies pain, denied chest pain, no SOB (shortness of breath) at this time. Lungs auscultated and bilaterally lower lobes wheeze observed. Nurse practitioner present in resident's room and suggested to be sent to ER for further evaluation. Charge nurse notified; PO (power of attorney) notified. Of Note: This is the first set VS or assessment documented since [DATE] at 1:56 PM. Hospital ER Note from [DATE] states in part . HPI: 101 y.o (year old) M (male) who presents with dyspnea and wheezing found today at the nursing home. History of dementia, kidney disease not chronically on albuterol. No fever. VS: T 97.1, P 97, R16, BP ,d+[DATE], O2 92% Physical Exam: Calls out please multiple times. Lungs: expiratory wheezes bilateral left greater that right. Psych: slightly anxious. ED (emergency department) Course and Medical Decision Making: In this patient with dyspnea, I have considered multiple etiologies. Heart failure certainly a possibility, he satting [sic] 92% on RA. He is hypertensive. [NAME] count 17, 5 bands 84 segs, potassium 5.7, has chronic hyperkalemia, BUN (blood urea nitrogen) 103, creatinine 5.3, slightly worse than normal for him. Chest x-ray shows left base infiltrate. IV (intravenous) Rocephin and Zithromax given. Admit given age and increased risk. Hospital History and Physical (H&P) from [DATE] states in part . In ED (emergency department): Afebrile, heart rate 97, blood pressure ,d+[DATE], RR (respiratory rate) 16, WBC (white blood cell count) 17, Hemoglobin 10.4, platelets 282, sodium 135, potassium 5.7, creatinine 5.3, GFR (glomerular filtration rate) 9, BUN 103, glucose 373, BNP (B-type natriuretic peptide) 384, chest x-ray concerning for left basilar infiltrate. Plan: Sepsis, Pneumonia, Acute Respiratory Failure with Hypoxia. -meeting criteria for sepsis with tachycardia + (positive) leukocytosis (increased white blood cells indicating infection) and source being pneumonia. Associated with acute on chronic kidney injury. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Currently on 2L (liters) to maintain sats >90%, received Rocephin and azithromycin in ED. -Currently hemodynamically stable, will check lactic acid and send blood cultures. Continue with Rocephin and azithromycin. Hypertension: significant elevated BP, will add low-dose hydralazine Acute on chronic kidney disease, hyperkalemia (elevated potassium), acidosis: Hx (history) of CKD4, cr (creatinine) 5.3 up from previous 4.4, K (potassium) 5.7 and bicarb 16; IVF (intravenous fluids), monitor strict I&O (intake and output), K down from previous 6; repeat BMP (basic metabolic panel) R5 expired on [DATE] at the hospital. On [DATE] at 12:50 PM, Surveyor interviewed NM C (Nurse Manager). Surveyor asked NM C what his expectations were for a resident who was to be monitored. NM C stated, if a resident is to be monitored would expect VS, cognition, pain all that every hour. On [DATE] at 1:00 PM, Surveyor interviewed RN G (Registered Nurse). Surveyor asked RN G if she remembered R5 and what she remembered from the day he was sent to the hospital. RN G stated, R5 was bad the previous day (before being sent out) and I called his son (AHCPOA) and told him R5 didn't sound good and asked if he was okay with sending him to the hospital. Surveyor asked RN G if she remembers how R5 was transported to the hospital. RN G stated, I can't remember if R5 was sent by ambulance or taxi. Oh, I remember now, R5 was sent to the hospital via taxi. I remember because the hospital called and said R5 should have not been sent via taxi. I should have called an ambulance. Surveyor asked RN G what SOP (standard of practice) the facility uses. RN G stated, I am not sure. Surveyor asked RN G if should be monitored, what would you expect to be done. RN G stated, check VS, lung sounds, pain level with VS q (every) 1 hour but check on them every 15 minutes. On [DATE] at 1:50 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B how staff determine what to use for transportation when sending a resident out to the hospital. DON B states we would need an order from MD then update family. Typically, if a resident is going to ER, we will send by ambulance. Surveyor asked DON B if a resident is to be monitored what her expectations would be for monitoring. DON B states I would expect staff would be doing lung sounds, VS, pain monitoring, turgor. Surveyor asked DON B how often that should be done. DON B stated, at least every hour. Surveyor reviewed R5's note indicating R5's son/AHCPOA wanted him monitored for a few hours then would make a decision on sending to the ER. Surveyor asked DON B if she would have expected staff to monitor R5. DON B stated, I would have expected more. DON B stated I would expect RN to be monitoring or MA (medication aide) to report to RN any data she collects or observations made. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 2:10 PM, Surveyor interviewed RN D (Registered Nurse). Surveyor asked RN D what monitoring of a resident for change of condition can be done by an MA. RN D stated, the MA should follow up on the residents status. Surveyor asked RN D what expectations for monitoring would be for the MA. RN D states check on the resident more frequently, probably every 1 hour and asking how they are doing. If concerns, then would report to another nurse, then VS and report and document what seeing. Surveyor asked RN D how staff determine what type of transportation the facility will use when transferring a resident to the hospital. RN D states if the resident is stable and going to the clinic I would send via taxi. If a resident is going to the ER I am sending them via ambulance. Surveyor asked RN D what SOP (Standard of Practice) the facility uses for change of condition. RN D stated, I don't know off the top of my head. On [DATE] at 2:25 PM, Surveyor interviewed CNA/MA E. Surveyor asked CNA/MA E what you would need to do when told a resident needs to be monitored. CNA/MA E states I would have to update the charge nurse, charge nurse completes any paperwork and MD notification. Check on the resident making sure nothing out of the ordinary, check VS and report changes. There is always an RN in the building when I am working. I would go to any floor RN with concerns if charge nurse is not here. Surveyor asked CNA/MA E if she had checked on or monitored R5 during her shift. CNA/MA E states there was nothing out of the ordinary that I can remember and if I didn't chart or anyone else didn't chart then it wasn't done. If a resident needs more frequent vitals it would be put in the MAR (Medication Administration Record)/TAR (Treatment Administration Record). On [DATE] at 3:30 PM, Surveyor interviewed NP F (Nurse Practitioner). Surveyor asked NP F if she could recall what R5 was presenting like. NP F stated, I saw him on [DATE] for my rounds and then again [DATE]. He was not on the list to be seen but staff were concerned and asked me to look at him. R5 reported when I saw him that he was more SOB (Short of Breath) but did not appear to be. I believe he requested to go out and I told staff that if he wanted to go to send him. I didn't feel that it was imminent. I was told his vitals were stable. Surveyor asked NP F if staff were to be monitoring R5 what her expectations would be for monitoring. NP F stated, I would expect them to monitoring lung sounds, VS, SPO2 (oxygen saturation) and checking on him every 15 to 30 minutes. Surveyor asked NP F if R5 had a known history of calling out. NP F stated, R5 did call out often due to PTSD (Post Traumatic Stress Disorder). Surveyor asked if she thought that R5 being transferred to the hospital by taxi was appropriate. NP F stated, I think that might have been okay but with my experience I wouldn't send via taxi. I don't know what was all going on. Of Note: NP F did not complete a progress note on [DATE] when she saw R5. During interview NP F indicates she is going off memory as she had no notes on the visit. 50698 Example 2 R4 admitted to the facility on [DATE]. R4's diagnoses include in part: Unspecified atrial fibrillation, muscle wasting and atrophy, Acute diastolic (congestive) heart failure, Hypertensive heart disease with heart failure (heart issues that develop due to long-term high blood pressure), Atherosclerotic heart disease of native coronary artery without angina pectoris (damage or disease in the heart's major blood vessels without chest pain), localized edema, venous insufficiency (chronic) (peripheral), Unspecified atherosclerosis of native arteries of extremities (buildup of substances in and on the artery walls), and long term (current) use of anticoagulants. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R4's Brief Interview for Mental Status (BIMS) was 12 out of 15 on the most recent Minimum Data Set (MDS) dated [DATE], which indicates R4's cognition is moderately impaired. R4 is her own decision maker. Nursing progress notes for R4 include, in part: Dated [DATE] at 4:50 AM, Resident was up to bathroom at 0430 with assist and walker, then returned to recliner, apical pulse (the heartbeat as it is felt at the apex (bottom) of the heart) 112 after walking to and from bathroom and continues with irregular that is fairly regular. States she feels tired and reminded her of time and she could sleep some more before having to get up for the day. Dated [DATE] at 2:31 PM, Resident denied weakness or dizziness this morning and stated when asked that she felt fine. Apical pulse this shift: 96 bpm (beats per minute) and continues to be irregular. Resident notified writer after her appointment, nearing the end of the shift, that she had experienced chest pressure this morning and sometime yesterday. Resident educated to notify staff immediately if this occurs. Resident stated it went away after drinking some fluids. Resident denied having any chest pressure or pain at this time. VS (vital signs) obtained and were stable, with the exception of irregular pulse. Resident's PCP (Primary Care Provider) is not in office. Writer attempted several times to notify on-call MD (Medical Doctor) without success. Left voicemail requesting to return call. On-coming nurse made aware. Will continue to monitor. Dated [DATE] at 4:48 PM, On-call MD returned call and was updated on resident history and situation. Stated that resident either needed to go to urgent care or to be seen by a provider sometime this week. Stated if apical pulse goes above 115 needs to go to urgent care/ER (emergency room) or receive treatment. Writer talked with resident. Resident stated that she was fine for now and did not want to go to ER at this time. Writer informed resident to let staff know if decides otherwise. Writer put resident down on physician rounds to be seen this week. Charge nurse is aware. It is important to note no other assessments were completed on R4 until 5:00 AM the next morning, which is about a 14.5 hours since the last assessment and MD stating to send R4 to the ER if her heart rate went above 115. Dated [DATE] at 6:29 AM, Residents HR (heart rate) upon awakening at 0500 was elevated with short bursts of tachycardia followed by short periods of bradycardia. HR was difficult to determine d/t (due to) erratic and rapid nature, but it did elevate to upwards of 120 when auscultating (using a stethoscope) but showing in the 90's on the pulse ox (pulse oximeter, an electronic device that measures the saturation of oxygen carried in your red blood cells and pulse). Resident is anticoagulated with Eliquis but does not at this time have a medication for rate control. PCP (primary care provider) office was notified via voicemail d/t the early hour, and the next shift was notified of these findings. Resident was informed of this, and she did state that she would be interested in having this treated since she is having some chest tightness with these episodes. Of note, R4 is presenting symptoms of tachycardia followed by bradycardia with a heart rate elevating to 120 and R4 is having chest tightness with these episodes at 0500. On call doctor stated the previous day R4 needs to go to urgent care/ER if apical pulse goes above 115, R4 stated she wanted to be treated. Facility left another voicemail for primary doctor without attempting another method of speaking with a physician. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Dated [DATE] at 9:51 AM, VM (voicemail) left with Dr. [name]'s office asking if the physician would be willing to see the resident today when he is in the building for rounds on one of his other patients. Awaiting return call. Dated [DATE] at 10:52 AM, Writer was informed by clinic staff that this resident's PCP is out of the office until the end of February, note charge nurse had placed a call to Dr. [name] asking if would see R4 while here for rounds with a return call received that Dr. [name] will see her today while in facility doing his rounds. Unit clerk faxing requested information to Dr. [name]s office to review prior to seeing her today. R4 updated on being seen at facility today. Apical HR 110 irregular after morning shower. Stated at times she has some chest pain and pointed to her mid sternum area when asked where, denied any type of radiating pain or back pain, denied shortness of breath, vertigo, or angina (chest pain) thus far today. Dated [DATE] at 1:01 PM, Continued to deny chest pain throughout the day. Dated [DATE] at 3:00 PM, Resident resting in recliner. Denies pain at this time but shared with writer that she had CP (chest pain) this morning and did not report it. VS as follows. Temp 98.0, HR 122 and irregular, resp 22, B/P ,d+[DATE] and sat 98% on RA. 1 + edema to lower extremities. R>L. Breath sounds with crackles to right base. Denies CP at this time. Dr. [name] in house and assessed. Order received to send to ER. Writer spoke with Dr. [name]'s MA (medical assistant) per his request to report VS. Writer also called Hospital ER and report given to nurse. It is important to note the in-house doctor assessed R4 10 hours after nurse noted R4 was presenting episodes of tachycardia and bradycardia, chest tightness, and a HR of 120. Dated [DATE] at 4:06 PM, HUC (health unit clerk) took resident to front office with scheduler at approximately 3:30 PM. Resident left facility around that time. Of note, this progress note does not specify how resident was transported to the hospital. Surveyor interviews with staff indicate resident went to the hospital via taxi. Dated [DATE] at 5:09 PM, Call from ER. Resident given 120mg Diltiazem with effective results. New order received for Diltiazem 120mg daily in the evening for BP/heart rhythm control. Potassium level was slightly low and troponin level slightly elevated but physician wasn't concerned with these lab results at this time as resident has reported chest discomfort as of late. Resident returning via taxi service soon. Dated [DATE] at 10:14 PM, Resident returned from hospital via taxi at approximately 5:20 PM. Ate toast and had coffee. Took scheduled medications. Denies CP (chest pain). HR (heart rate) 89 and irregular. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Surveyor reviewed the ER report from [DATE]. It states, in part: presents with rapid heart rate on and off this week, she says is worse in the morning and then it resolves, does have a history of A-fib (irregular heart rate). Denies any pain, says she can feel her heart racing in the morning and that it seems to stop. EKG: A-fib RVR (rapid ventricular response) with a wide complex. ED Course and Medical Decision Making: Emerged from her course consisted of 5mg verapamil, her heart rate came from the 160's down to the 90's, patient felt better, will discharge home, diagnose A-fib RVR. She will be started on Cardizem CD 120mg p.o. (by mouth) nightly, follow-up with her doctor, return for worsening symptoms. Patient was resting comfortably here in the Emergency Department. Prescriptions: New Diltiazem HCl 120mg capsule, extended release 24 hr - 120mg PO daily. On [DATE] at 1:23 PM, Surveyor interviewed RN H (Registered Nurse) regarding how R4 got transported to hospital on [DATE] as her nursing note did not specify the transportation used. Nurse stated she wasn't sure which transportation service was used, stated the charge nurse, RN C, took care of the transportation. RN H stated she remembers resident coming back to facility via taxi on [DATE]. On [DATE] at 1:35 PM, Surveyor interviewed RN C and asked how resident was transported to the hospital on [DATE]. RN C indicated an ambulance was used and gave Surveyor the phone number for the ambulance service. On [DATE] at 2:04 PM, Surveyor called the ambulance service and they told Surveyor no call was placed from the facility on [DATE], stated they didn't go to the facility at all on [DATE]. On [DATE] at 2:18 PM, Surveyor interviewed RN C again to ask if it was possible a different ambulance service was used to transport resident. RN C stated no, it would have been the one he told Surveyor prior. Surveyor then asked if it was possible a taxi service was used to transport resident to hospital. RN C stated yes, it was possible and gave Surveyor phone number for the taxi service the facility uses. On [DATE] at 2:26 PM, Surveyor called the taxi service and the manager indicated they were called to come to the facility to pick up R4, left facility at 3:40pm and transported her to theER on [DATE], arrived at ER at 3:51pm. Of note, R4 was presenting with symptoms of tachycardia (elevated heart rate), bradycardia (low heart rate), a HR of 122 and irregular, and R4 having chest tightness with these episodes. Facility chose to send the resident to ER via taxi instead of an ambulance. On [DATE] at 5:35 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B when contacting the physician for a residents change of condition, in what circumstances is it okay to leave a voicemail versus speak with a physician. DON B stated, A lot of times when we are calling the physician it is during office hours, so we are leaving a message and waiting for a return call. Surveyor asked DON B how long the typical wait was for the physician to return the call. DON B states, It depends. Surveyor asked DON B how long do staff wait for a return call before they contact another provider or send a resident out. DON B stated, That also depends on the situation. Surveyor asked when Standards of Practice indicates immediate notification to MD, is it okay to leave a message or voicemail. DON B stated, I don't think we have any option but to wait for them to call us back or we would just be sending out. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Staff failure to recognize an acute change in condition, failure to closely monitor and assess a resident with an acute change in condition, and failure to send a resident to the hospital via ambulance rather than a taxi during an acute change of condition resulted in a delay of treatment and alternative interventions which created a finding of immediate Jeopardy. The Facility removed the jeopardy on [DATE] when it had completed the following: Staff education started on [DATE] in regard to Change in condition ie: what is a change in condition, how to recognize, appropriate response to COC, Physician notification as well as assessments required for COC. Staff are required to review prior to the start of their shift. Staff are educated to to assess the resident for the COC, gather Vitals, symptoms, changes above baseline condition, at a minimum of twice a shift or transferred for further evaluation. MD should notified upon the COC, vitals, symptoms, interventions, reactions, pain, infections, neurological changes, falls, As soon as possible following COC. We have a scheduled Mandatory all staff meeting on [DATE] at 06:00am and 02:30pm in regard to COC and follow up from education provided to ensure they are understanding of requirements and to obtain feedback. Education will be provided for new hires during orientation time in the form of educations that are provided for the staff above, agency will be given the same information. Starting [DATE] management staff will be doing scenario-based competencies with management acti [TRUNCATED]

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F 0729 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Verify that a nurse aide has been trained; and if they haven't worked as a nurse aide for 2 years, receive retraining. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36253 Based on interview and record review, the facility did not ensure that a Certified Nursing Assistant (CNA) was currently certified on the Nurse Aide Registry before continuing to work in the facility for 1 of 5 staff reviewed. CNA E's Wisconsin Nurse Aide Registry certification was expired and CNA E continued working in the facility. Findings include: According to the Wisconsin Nurse Aide Training and Registry, nurse aides must be listed on the Wisconsin Nurse Aide Registry in order to be employed in any federally eligible health care setting in Wisconsin. On [DATE], Surveyor reviewed CNA registry information for 5 random CNAs. CNA E was listed on the registry, but her certification had expired on [DATE]. CNA E had worked in the facility 11 days since the expiration of her certification according to documentation provided by the facility. On [DATE] at 11:15 AM, Surveyor interviewed NHA A (Nursing Home Administrator) about the expired CNA Registry for CNA E. NHA A stated that she was unaware until today that CNA E's certification had expired. NHA A stated that she called CNA E today when the registry expiration was discovered. NHA A indicated CNA E stated that she had submitted it weeks previous to her other employer, a local hospital, but had not heard back. NHA A stated that she would submit the appropriate paperwork on behalf of the facility to ensure her certification gets renewed as soon as possible

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 36253 Based on interview and record review the facility did not complete a performance review of every nurse aide at least once every 12 months for 3 of 5 Certified Nursing Assistants (CNAs) reviewed. CNA K did not have an annual performance evaluation completed. CNA L did not have an annual performance evaluation completed. CNA M did not have an annual performance evaluation completed. This is evidence by: The Facilities Policy and Procedure entitled Training/competencies of Nursing Staff dated 8/4/17 documents, in part: The facility will complete a performance review of every CNA at least once every 12 months and provide regular in service education based on the outcome of these reviews. Example 1 CNA K's hire date was 8/6/18. CNA K did not have an annual performance evaluation completed. Example 2 CNA L's hire date was 11/19/18. CNA L did not have an annual performance evaluation completed. Example 3 CNA M's hire date was 10/25/22. CNA M did not have an annual performance evaluation completed. On 3/31/25 at 1:30 PM, Surveyor interviewed NHA A (Nursing Home Administrator). Surveyor asked NHA A how often are CNA evaluations to be done, NHA A said yearly. Surveyor asked NHA A should all CNA's have an up-to-date evaluation, NHA A stated, Yes.