

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  04/03/2024
NAME OF PROVIDER OR SUPPLIER  Pine Valley Community Village		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39713</p> <p>Based on interview and record review, the facility failed to ensure the reporting of a reasonable suspicion of a crime for 2 of 2 residents (R) with allegations of abuse to law enforcement (R49 and R58).</p> <p>On 8/6/23, R58 made an allegation of abuse against a staff member. Law Enforcement was not contacted immediately after the allegation of R58 stating, The black man hurt me last night.</p> <p>R49 made an allegation of abuse and the facility did not contact local law enforcement.</p> <p>Findings include:</p> <p>Surveyor reviewed the facility's Policy and Procedure, Abuse, Neglect and Exploitation dated 5/13/13, last reviewed 3/06/24, noting the following as applicable:</p> <p>B. Thorough Investigation: Upon learning of an alleged incidents and having protected the resident a thorough investigation focused on collecting information that corroborates or disproves the incident will immediately begin. This investigation process will be directed by the administrator or designee and may include the following depending on circumstances:</p> <p>m. Involve other regulatory authorities who may assist, e.g., local law enforcement, adult protective services, elder abuse agency.</p> <p>V. Procedure for Abuse Reporting: upon discovery of alleged violations involving mistreatment: neglect, or abuse, including injuries of unknown source, and misappropriation of resident's property, immediately protect the resident and report the incident to your supervisor who in turn needs to immediately contact the administrator or designee. Furthermore, it is the policy of [Facility Name] to comply with the Elder Justice Act (EJA) and in doing so all facility staff are obligated to report any reasonable suspicion of a crime, as defined by law, committed against an individual residing at or receiving care from [Facility Name].</p> <p>Example 1:</p> <p>(continued on next page)</p>		

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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R58 was readmitted to the facility on [DATE] with diagnoses that include: metabolic encephalopathy (a condition in which brain function is disturbed temporarily or permanently due to underlying conditions or toxins in the body), depression, type 2 diabetes mellitus, nontraumatic intracerebral (brain) hemorrhage (brain hemorrhage occurs when an artery in the brain bursts and causes bleeding), muscle wasting (condition where muscles lose mass and strength), and atrophy (wasting or thinning of muscle mass).</p> <p>The Quarterly Minimum Data Set (MDS) dated [DATE] indicates R58 has a Brief Interview for Mental Status (BIMS) of 3, indicating severe cognitive impairment. R58 requires partial/moderate assistance with eating, substantial/maximum assistance with oral hygiene, bathing, and upper body dress, and R58 is dependent on staff for lower body dressing and toileting.</p> <p>Surveyor reviewed the facility self-report which stated on 8/6/23 at 5:30 AM that R58 reported to the RN (Registered Nurse) that, The black man last night hurt me. The RN asked R58 how the person hurt him and R58 stated, With his hands. The RN then asked R58 for more details and R58 was unable to offer more specifics on how he was hurt but did say that, He hurt me, I told him it was hurting and he didn't stop.</p> <p>According to the facility self-report on 8/6/23, NHA A (Nursing Home Administrator) was made aware of R58 stating someone had hurt him and the facility initiated an investigation and submitted a report to Division of Quality Assurance (DQA). Surveyor noted that law enforcement was not contacted by the facility on 8/6/23.</p> <p>On 4/2/24 at 1:38 PM, Surveyor interviewed SW H (Social Worker). Surveyor asked SW H what the self-report from 8/6/23 was regarding. SW H stated, this was about an allegation of abuse. Surveyor asked SW H if the police were notified of the abuse allegation. SW H stated, no. Surveyor asked SW H if the police should have been notified of the allegation of abuse. SW H stated, that is open to interpretation but in this case we did not.</p> <p>On 4/2/24 at 1:48 PM, Surveyor spoke with DON B (Director of Nursing) and NHA A regarding the allegation of abuse. NHA A and DON B both indicated that the police needed to be notified of all allegations of abuse.</p> <p>36253</p> <p>Example 2:</p> <p>R49 was admitted to the facility on [DATE].</p> <p>On 9/24/24, staff reported to facility administration that R49 had stated that CNA D (Certified Nursing Assistant) was rough with her during a transfer from R49's wheelchair to the bathroom on the previous PM shift (9/23/24). The facility submitted an initial report to the state agency and indicated on the submission form that the incident was abuse. The facility conducted an investigation including interviews with other staff and residents. CNA D was not allowed back at the facility after the event. When the facility interviewed R49 on 9/24/24, R49 stated that she was being pushed by CNA D during the incident and that she was scared during the transfer. R49 stated that she believed CNA D's actions were purposeful and also indicated that her arm was hurting after the cares performed by CNA D.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility did not report the alleged abuse to local law enforcement.</p> <p>On 4/3/24 at 1:36 PM, Surveyor interviewed SW C (Social Worker) who submitted the original report to the state agency and completed the investigation. SW C stated that the incident was not reported to local law enforcement as abuse has a lot of factors. SW C stated, It's kind of hard to say it's abuse. When asked if the words scared and pushing mean abuse, SW C stated, I'm not going to say it's not abuse.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 36253</p> <p>Based on observation and interview, the facility did not store, prepare, distribute, and serve food in accordance with professional standards for food service safety. This has the potential to affect all 62 Residents.</p> <p>Nutritional supplements and food items were not dated or were expired.</p> <p>Boxes of food were observed sitting on the floor in multiple areas of the kitchen.</p> <p>Facility staff was observed walking through the kitchen without a hairnet.</p> <p>The temperature of a dishwasher was not being monitored.</p> <p>Findings include:</p> <p>The facility employs 4 separate kitchenettes in each of its units (200, 300, 400, 500) to prepare, serve, and store food. These kitchenettes include a refrigerator, pantry, steam tables, and each have a high temperature dishwasher to clean dishes on the unit.</p> <p>Example 1</p> <p>On [DATE] at 6:58 PM, Surveyor observed the following, along with RN E (Registered Nurse), in each of the facility's kitchenette refrigerators:</p> <p>200 unit - 2 nutritional juices with no thaw dates. A 32 oz bottle of half and half with a use-by date of [DATE].</p> <p>300 unit - 3 nutritional shakes with no thaw dates on them.</p> <p>400 unit - 2 nutritional shakes with [DATE] as a thaw date and a bowl of tuna with mayo with out a date.</p> <p>500 unit - 12 nutritional shakes with no thaw dates.</p> <p>It should be noted that the nutritional shakes and juices are stored in the freezer. The manufacture's recommendations, as printed on the containers of the nutritional shakes and juices, states, Use within 14 days of thawing. RN E, who is an RN manager, stated she was unaware of the process of pulling the nutritional shakes and juices.</p> <p>On [DATE] at 1:59 PM, DM F (Dietary Manager) stated that the facility does not have a policy or procedure as it pertains to nutritional shakes and drinks.</p> <p>Example 2</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On [DATE] at 11:02 AM, Surveyor observed 5 or more boxes of food sitting directly on the floor in the following ares: dry storage, two freezers, and the refrigerator in the main kitchen. DM F stated that the boxes should not be on the floor.</p> <p>Example 3</p> <p>On [DATE] at 6:49 PM, Surveyor observed RN G walk through the kitchen without a hairnet to get food items.</p> <p>On [DATE] at 1:59 PM, DM F stated to Surveyor that it is her expectation that any staff, regardless of time, that walks into the kitchen wear a hair net. DM F stated that there was a sign posted on the entrance door to the kitchen that states this.</p> <p>Example 4</p> <p>On [DATE] at 1:38 PM, Surveyor observed the small dishwashers in each of the facility's kitchenettes. Each kitchenette's high temperature dishwasher is monitored by a non-regressing thermometer that documents the internal temperature. Surveyor was unable to find a thermometer in the 400 unit kitchenette or evidence of its use to document the dishwasher's temperature on the 400 unit.</p> <p>On [DATE] at 1:59 PM, DM F stated to Surveyor that there was not a thermometer on the 400 unit and she was not sure when it disappeared and was not sure how long the internal temp of the dishwasher was not being monitored on the 400 unit kitchenette. DM F stated it was her expectation that the staff use the non-regressing thermometer and got a new one for the 400 kitchenette.</p>		