STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525409	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine View Care Center	400 County Rd R Black River Falls, WI 54615

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525409	A. Building B. Wing	12/03/2025

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect 1 of 3 residents (R1) right to be free from verbal abuse by a Certified Nursing Assistant (CNA).CNA G (Certified Nursing Assistant) was observed to be swearing at and treating R1 roughly when assisting with needs.Evidenced by:The facility policy titled Resident Safety Abuse Policy last reviewed 3/2024 states in part It is the policy of our facility to maintain a work and living environment that is professional and free from threat and/or occurrence of harassment, abuse (verbal, physical, mental or sexual), neglect, corporal punishment, involuntary seclusion, physical or chemical restraints not required to treat the resident's medical symptoms, exploitation and misappropriation of resident property.Providing a safe environment is one of the most basic and essential duties of the facility. Employees have a unique position of trust with vulnerable residents. Having access to private information, being in a physically intrusive position and having elevated status and special relationships with residents, makes ethical and professional behavior essential.Our facility promotes an atmosphere of sharing with residents and staff without fear of retribution.Residents have the right to be free from abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, visitors, friends, or other individuals.The system cannot guarantee that abuse will never occur. It can only assure that the facility is doing all that is within its control to prevent occurrences.Protocol: Federal Definitions: a. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish. This includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury. b. Verbal Abuse is defined as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to: threats of harm, saying things to frighten a resident, such as telling a resident that he/she will never be able to see his/ her family again.R1 was admitted to the facility on [DATE] with diagnoses that include renal cancer, urine retention, and hydronephrosis (where something keeps urine from flowing from the kidneys to the bladder).R1's care plan dated 10/28/25 indicates that R1 requires assistance from 2 staff members for transfers with a full body lift and requires assistance from staff for ADLs (Activities of Daily Living).On 12/3/25 at 10:19 AM, Surveyor interviewed R1. Surveyor asked R1 how things were going for them in the facility, R1 stated My bath is like a party of butchers. What they do to me makes me feel like I'm an animal. Surveyor asked R1 if staff are rough with them, R1 stated that staff do not take their time with them or handle them easy. Surveyor asked R1 if staff swear around them, R1 stated yes. Surveyor asked R1 if they were willing to share the names of the staff members and R1 stated no, and that they were afraid. Surveyor asked R1 if they reported their concerns to anyone, R1 stated that they reported it to the main person that runs the place.On 12/3/25 at 12:30 PM, Surveyor interviewed RN F (Registered Nurse). Surveyor asked RN F if they were aware of any allegations of abuse regarding R1, RN F stated that a few weeks ago, Hskpr E (Housekeeper) reported that they had witnessed CNA G cursing and being rough with R1. Surveyor asked RN F if they reported the allegation, RN F stated that it was reported to NHA A (Nursing Home Administrator). Surveyor asked RN F if CNA G (Certified Nursing Assistant) was removed from resident care, RN F stated no.On 12/3/25 at 1:30 PM, Surveyor interviewed Hskpr E. Surveyor asked Hskpr E to explain the events regarding R1 and CNA G, Hskpr E reported that they were cleaning R1's room and noted that R1 needed assistance because his pant leg was caught on their wheelchair, and they were not able to move. Hskpr E told CNA G that R1 needed help and that CNA G appeared mad when they entered R1's room. Hskpr E reported that CNA G stated, I told you to stop fucking with shit and proceeded to pick up R1's legs roughly and put them on the wheelchair pedals. CNA G left R1's room, and R1 was still unable to move; R1 then requested to be placed in their recliner. Hskpr E reported that they alerted CNA G, and then left R1's room to go clean another. Hskpr E reported that they could hear CNA G yelling at R1 from down the hall. Surveyor asked Hskpr E if they

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525409	A. Building B. Wing	12/03/2025

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview and record review, the facility did not ensure that the policy and procedures that prohibit mistreatment, abuse, and neglect of residents were implemented for 2 of 3 residents (R1 and R2) reviewed for abuse. The facility did not implement their abuse policy and procedure as the facility did not report allegations of abuse to the State Agency, did not fully investigate allegations of abuse or put measures in place to protect residents while an investigation was occurring for abuse allegations involving R1 and R2. Evidenced by: The facility's policy titled Resident Safety Abuse Policy last reviewed on 3/2024 states in part .8. Reporting Suspected Violations: a. The supervisor on duty shall IMMEDIATELY safeguard the resident(s) and immediately report all alleged violations involving abuse, neglect, mistreatment, exploitation, including injuries of unknown source and misappropriation of resident property to the facility administrator, the Administrator will notify the DON (Director of Nursing) and/or others as appropriate. b. The administrator will report a reasonable suspicion of a crime against any individual who is a resident of or is receiving care from the facility to the State Agency and one or more law enforcement entities for the political subdivision in which the facility is located. c. The administrator shall report immediately, but not later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or no later than 24 hours if the events that cause the suspicion do not result in serious bodily injury. 9. Procedure For Investigation: a. All alleged violations will be thoroughly investigated, and all investigations are conducted by or coordinated through facility administration.d. The supervisor will ensure that the resident(s) is/are protected from further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.g. An employee suspected of violation of the Resident Safety Abuse Policy or Social Media Policy may be suspended pending investigation. Example 1 On 11/15/25, Hskpr E (Housekeeper) reported to RN F (registered Nurse) that CNA G (Certified Nursing Assistant) was yelling/swearing and was rough when assisting R1. On 12/3/25 at 12:30 PM, Surveyor interviewed RN F. Surveyor asked RN F if they were aware of any allegations of abuse regarding R1, RN F stated that a few weeks ago, Hskpr E reported that they had witnessed CNA G cursing and being rough with R1. Surveyor asked RN F if they reported the allegation, RN F stated that it was reported to NHA A (Nursing Home Administrator). Surveyor asked RN F if CNA G was removed from resident care, RN F stated no. (continued on next page)

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	525409	A. Building B. Wing	12/03/2025

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/3/25 at 1:30 PM, Surveyor interviewed Hskpr E. Surveyor asked Hskpr E to explain the events regarding R1 and CNA G, Hskpr E reported that they were cleaning R1's room and noted that R1 needed assistance because his pant leg was caught on their wheelchair, and they were not able to move. Hskpr E told CNA G that R1 needed help and that CNA G appeared mad when they entered R1's room. Hskpr E reported that CNA G stated, I told you to stop fucking with shit and proceeded to pick up R1's legs roughly and put them on the wheelchair pedals. CNA G left R1's room, and R1 was still unable to move; R1 then requested to be placed in their recliner. Hskpr E reported that they alerted CNA G, and then left R1's room to go clean another. Hskpr E reported that they could hear CNA G yelling at R1 from down the hall. Surveyor asked Hskpr E if they reported the incident, Hskpr E stated they reported it to RN F. Surveyor asked Hskpr E if they asked CNA G to leave R1's room or remove R1 from the situation, Hskpr E stated no. It is important to note that Surveyor requested the investigation regarding R1. Facility staff provided 3 handwritten interviews that did not include an interview time and/ or signature of interviewee. There were no additional interviews from residents or staff. On 12/3/25 at 2:30 PM, Surveyor interviewed NHA A. Surveyor asked NHA A if they were aware of the allegation of abuse regarding R1 and CNA G, NHA A stated that they received a call about the incident and initiated an investigation. NHA A reported that they received a call from RN F reporting that Hskpr E reported an allegation of abuse, stating that CNA G was yelling and being rough with R1. Surveyor asked NHA A if that is an allegation of abuse, NHA A stated yes. Surveyor asked NHA A if they completed a complete investigation, NHA A stated yes. Surveyor asked if they reported the incident to the State Agency, NHA A stated no. Surveyor asked NHA A if they interviewed other staff and residents, NHA A stated no. Surveyor asked NHA A if CNA G was removed from patient care during the investigation, NHA A stated no. Example 2: R2 admitted to facility on 8/22/25 and has diagnoses that include atrial fibrillation (irregular heartbeat where the upper chambers of the heart quiver due to misfiring electrical signals) and hypertension (high blood pressure). R2's Grievance Report, dated 9/25/25, states, in part: . Describe the situation/issue/complaint: FM D (Family Member) expressed concern of the approach staff had with R2 while transferring her with the EZ stand. She stated they were abrupt with her and had an inappropriate way of communicating with her. Summary statement of resident's grievance: FM D of R2 states staff were using an inappropriate approach when transferring her sister. They made statements such as She was unmotivated, non-compliant, refusing cares and told R2 she could remain in chair. Summary of investigation findings and conclusion: R2 was recently changed to an EZ stand for a transfer status. She was not given proper instruction on how to use the stand and was anxious. Staff are being educated on how to handle these situations more effectively. They were educated on approach with all residents, providing respect, and how to handle various situations with different abilities. Corrective actions taken as a result of the grievance: (continued on next page)

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	525409	A. Building B. Wing	12/03/2025

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Education on approach with various situations with various abilities of residents -Education on how to handle these situations effectively -R2 is a Hoyer lift- she has adjusted well with this transition. Facility provided interviews with R2, FM D, and 2 cnas (1 that worked with R2 that evening of concern. 1cna that was not on shift the evening of concern). Surveyor reviewed the facility's education on Approach with Residents, dated 9/25/25, to nursing staff on approach with residents and various situations with different [sic], how to handle situations effectively. There are twenty-four nursing staff signatures. Surveyor reviewed education on Resident Rights/Safety & Abuse Policy, dated 10/09/25, to all staff on understanding approaches with residents and understanding how to go with different situations. Understanding resident rights after background. Resident safety & abuse. There were twenty-nine signatures. On 12/03/25 at 11:20 AM, Surveyor interviewed FM D. FM D indicated there was one incident that occurred a few weeks after R2 admitted to the facility in September. R2 had to use the bathroom. FM D indicated a cna (certified nursing assistant) was attempting to transfer R2 out of chair with EZ stand. This was new to R2, she had not used an Ez stand prior. CNA was trying to get R2 up and was giving different directions to R2 on how to get up with the EZ stand. The cna was using a very stern voice while speaking to R2 which was causing R2 to become anxious and confused. The cna said to R2 R2 you got to do this! in a strong stern voice. R2 could not understand what to do. FM D indicated the cna was saying R2 was being non-compliant and refusing. FM D indicated that was not the case, R2 was not getting good direction on what to do and was spoken to sternly causing her to become anxious and confused. The cna stated I cannot do this anymore. You can go to the bathroom in the chair and sleep there, and left the room. R2 still had to use the bathroom. FM D indicated another staff member entered the room and said, What is this bullshit going on in here? FM D indicated she did not know the names of the staff members. FM D indicated to Surveyor, FM D thought if the staff talk to the residents like this in front of family, how do they treat residents when family is not around. FM D indicated the next day she took this concern to the social worker. (continued on next page)

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	525409	A. Building B. Wing	12/03/2025

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/03/25 at 12:29 PM, Surveyor interviewed SW C (Social Worker). Surveyor asked SW C if she recalled an incident that was reported to her by FM D regarding staff interactions with R2 in September. SW C indicated she recalled an incident with R2 being uneasy with the EZ stand; R2 had been a stand pivot transfer and had just changed to an EZ stand transfer. SW C indicated FM D voiced concern that staff's approach was not up to standards when interacting with R2. Surveyor asked SW C what was meant by that. SW C indicated R2 was nervous and uneasy with the EZ stand and staff were not patient with R2 and used a tone of voice with R2 when communicating with her. Surveyor asked SW C if she could explain what is meant by tone of voice. SW C indicated FM D informed her that staff told R2 she could just stay in the chair if she would not transfer out of it. Surveyor asked SW C if there was documentation of this incident, SW C indicated it was filed as a grievance. Surveyor asked SW C what the process is when a concern is brought forward. SW C indicated a grievance form is filled out and investigated. SW C indicated depending on what the outcome of the investigation, the grievance would be given to the administrator and the appropriate action to take would be decided. SW C obtained the grievance and Surveyor and SW C went over it. Surveyor asked SW C what was meant by Inappropriate approach, and being abrupt with R2. SW C indicated staff were being very short and very direct with R2 instead of explaining the process on how to transfer using the EZ stand with R2. Surveyor asked SW C if this incident could be considered an allegation of abuse. SW C indicated staff telling R2 she could stay in chair and not be transferred, yes. Surveyor asked SW C if an allegation of abuse should be reported to the state. SW C indicated any time there is an allegation of abuse it should be reported within 2 hours. SW C expressed FM D just wanted the staff's approach with R2 to be handled. Surveyor asked SW C if she was a mandatory reporter and SW C indicated yes. Surveyor asked if a self-report had been filed, and SW C indicated she did not know. On 12/03/25, at 2:00PM, Surveyor interviewed NHA A (Nursing Home Administrator) and asked if she was aware of the incident with R2 and staff in September. NHA A indicated yes. Surveyor asked when NHA A became aware of the incident, and NHA A indicated that day, 9/25/25. Surveyor asked if a resident is told they can stay in the chair, go to the bathroom in the chair and sleep in the chair is an allegation of abuse. NHA A indicated yes. Surveyor asked if this incident was reported to the state. NHA A indicated the facility has two hours to investigate the allegation to determine if it was abuse and report to the state in two hours if it was. NHA A indicated she had not reported it to the state. Surveyor referred NHA A to the State of Operations Manual tag F609 and F610. Surveyor asked NHA A what the facility's process is for an allegation of abuse. NHA A indicated to investigate it, interview staff that are involved, complete skin checks, and interview staff. Surveyor asked if the facility completed a full investigation of the incident and NHA A indicated no. The facility did not follow or implement their abuse policy and procedure for two abuse allegations involving R1 and R2.

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	525409	A. Building B. Wing	12/03/2025

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility did not ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, are reported immediately to the administrator of the facility and to other officials, including the State Survey Agency, in accordance with State law though established procedures for 2 of 3 residents (R1and R2) reviewed for abuse allegations. A facility staff member reported an allegation of abuse regarding R1 that was not reported to the State Agency or police. R2's family member reported an allegation of abuse that was not reported to the State Agency or police. Evidenced by: The facility's policy titled Resident Safety Abuse Policy last reviewed on 3/2024 states in part .8. Reporting Suspected Violations: a. The supervisor on duty shall IMMEDIATELY safeguard the resident(s) and immediately report all alleged violations involving abuse, neglect, mistreatment, exploitation, including injuries of unknown source and misappropriation of resident property to the facility administrator, the Administrator will notify the DON (Director of Nursing) and/or others as appropriate. b. The administrator will report a reasonable suspicion of a crime against any individual who is a resident of or is receiving care from the facility to the State Agency and one or more law enforcement entities for the political subdivision in which the facility is located. c. The administrator shall report immediately, but not later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or no later than 24 hours if the events that cause the suspicion do not result in serious bodily injury. 9. Procedure For Investigation: a. All alleged violations will be thoroughly investigated, and all investigations are conducted by or coordinated through facility administration.d. The supervisor will ensure that the resident(s) is/are protected from further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.g. An employee suspected of violation of the Resident Safety Abuse Policy or Social Media Policy may be suspended pending investigation. Example 1 On 11/15/25, NHA A (Nursing Home Administrator) was made aware of an allegation of abuse regarding R1 and CNA G (Certified Nursing Assistant). It is important to note that Surveyor requested the investigation regarding R1. Facility staff provided 3 handwritten interviews that did not include an interview time and/ or signature of interviewee. There were no additional interviews from residents or staff. On 12/3/25 at 2:30 PM, Surveyor interviewed NHA A. Surveyor asked NHA A if they were aware of the allegation of abuse regarding R1 and CNA G, NHA A stated that they received a call about the incident and initiated an investigation. NHA A reported that they received a call from RN F reporting that Hskpr E reported an allegation of abuse, stating that CNA G was yelling and being rough with R1. Surveyor asked NHA A if that is an allegation of abuse, NHA A stated yes. Surveyor asked if they reported the incident to the State Agency, NHA A stated no. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Of note: there is no evidence the allegation was reported to law enforcement. Example 2: R2 admitted to facility on 8/22/25 and has diagnoses that include atrial fibrillation (irregular heartbeat where the upper chambers of the heart quiver due to misfiring electrical signals) and hypertension (high blood pressure). R2's Grievance Report, dated 9/25/25, states, in part: . Describe the situation/issue/complaint: FM D (Family Member) expressed concern of the approach staff had with R2 while transferring her with the EZ stand. She stated they were abrupt with her and had an inappropriate way of communicating with her. Summary statement of resident's grievance: FM D of R2 states staff were using an inappropriate approach when transferring her sister. They made statements such as She was unmotivated, non-compliant, refusing cares and told R2 she could remain in chair. Facility's interview with FM D, dated 9/25/25, no time, states: States staff were using an inappropriate approach with R2. -Non-compliant, refusing cares, unmotivated -States they told her she can stay in her chair, you can fall on the floor -R2 became emotional, tearful, confused -She was hesitant to put her call light on because they won't help me anyway. Facility's Interview with R2, dated 9/25/25, no time, states: They told me to sleep in my chair, so I transferred myself into my bed. They kept saying This is bullshit. This is bullshit. On 12/03/25 at 11:20 AM, Surveyor interviewed FM D. FM D indicated there was on incident that occurred a few weeks after R2 admitted to the facility in September. R2 had to use the bathroom. FM D indicated a cna (certified nursing assistant) was attempting to transfer R2 out of chair with EZ stand. This was new to R2, she had not used an Ez stand prior. CNA was trying to get R2 up and was giving different directions to R2 on how to get up with the EZ stand. The cna was using a very stern voice while speaking to R2 which was causing R2 to become anxious and confused. The cna said to R2 R2 you got to do this! in a strong stern voice. R2 could not understand what to do. FM D indicated the cna was saying R2 was being non-compliant and refusing. FM D indicated that was not the case, R2 was not getting good direction on what to do and was spoken to sternly causing her to become anxious and confused. The cna stated I cannot do this anymore. You can go to the bathroom in the chair and sleep there, and left the room. R2 still had to use the bathroom. FM D indicated another staff member entered the room and said, What is this bullshit going on in here? FM D indicated she did not know the names of the staff members. FM D indicated to Surveyor, FM D thought if the staff talk to the residents like this in front of family, how do they treat residents when family is not around. FM D indicated the next day she took this concern to the social worker. (continued on next page)

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	525409	A. Building B. Wing	12/03/2025

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/03/25, at 12:29PM, Surveyor interviewed SW C (Social Worker). Surveyor asked SW C if she recalled an incident that was reported to her by FM D regarding staff interactions with R2 in September. SW C indicated she recalled an incident with R2 being uneasy with the EZ stand; R2 had been a stand pivot transfer and had just changed to an EZ stand transfer. SW C indicated FM D voiced concern that staff's approach was not up to standards when interacting with R2. Surveyor asked SW C what was meant by that. SW C indicated R2 was nervous and uneasy with the EZ stand and staff were not patient with R2 and used a tone of voice with R2 when communicating with her. Surveyor asked SW C if she could explain what is meant by tone of voice. SW C indicated FM D informed her that staff told R2 she could just stay in the chair if she would not transfer out of it. Surveyor asked SW C if there was documentation of this incident, SW C indicated it was filed as a grievance. Surveyor asked SW C what the process is when a concern is brought forward. SW C indicated a grievance form is filled out and investigated. SW C indicated depending on what the outcome of the investigation, the grievance would be given to the administrator and the appropriate action to take would be decided. SW C obtained the grievance and Surveyor and SW C went over it. Surveyor asked SW C what was meant by Inappropriate approach, and being abrupt with R2. SW C indicated staff were being very short and very direct with R2 instead of explaining the process on how to transfer using the EZ stand with R2. Surveyor asked SW C if this incident could be considered an allegation of abuse. SW C indicated staff telling R2 she could stay in chair and not be transferred, yes. Surveyor asked SW C if an allegation of abuse should be reported to the state. SW C indicated any time there is an allegation of abuse it should be reported within 2 hours. SW C expressed FM D just wanted the staff's approach with R2 to be handled. Surveyor asked SW C if she was a mandatory reporter and SW C indicated yes. Surveyor asked if a self-report had been filed, and SW C indicated she did not know. On 12/03/25, at 2:00PM, Surveyor interviewed NHA A (Nursing Home Administrator) and asked if she was aware of the incident with R2 and staff in September. NHA A indicated yes. Surveyor asked when NHA A became aware of the incident, and NHA A indicated that day, 9/25/25. Surveyor asked if a resident is told they can stay in the chair, go to the bathroom in the chair and sleep in the chair is an allegation of abuse. NHA A indicated yes. Surveyor asked if this incident was reported to the state. NHA A indicated the facility has two hours to investigate the allegation to determine if it was abuse and report to the state in two hours if it was. NHA A indicated she had not reported it to the state. Of note: there is no evidence the allegation was reported to law enforcement. Allegations of abuse involving R1 and R2 were not reported to the state survey agency within the required time frame and were not reported to law enforcement.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525409	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview, and record review, the facility did not ensure that in response to allegations of abuse, neglect, exploitation, or mistreatment, that alleged violations are thoroughly investigated for 2 of 3 residents (R1 and R2) reviewed for abuse. A facility staff member reported an allegation of abuse regarding R1 that was not thoroughly investigated. R2's family member reported an allegation of abuse that was not thoroughly investigated. Evidenced by: The facility's policy titled Resident Safety Abuse Policy last reviewed on 3/2024 states in part .8. Reporting Suspected Violations: a. The supervisor on duty shall IMMEDIATELY safeguard the resident(s) and immediately report all alleged violations involving abuse, neglect, mistreatment, exploitation, including injuries of unknown source and misappropriation of resident property to the facility administrator, the Administrator will notify the DON (Director of Nursing) and/or others as appropriate. b. The administrator will report a reasonable suspicion of a crime against any individual who is a resident of or is receiving care from the facility to the State Agency and one or more law enforcement entities for the political subdivision in which the facility is located. c. The administrator shall report immediately, but not later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or no later than 24 hours if the events that cause the suspicion do not result in serious bodily injury. 9. Procedure For Investigation: a. All alleged violations will be thoroughly investigated, and all investigations are conducted by or coordinated through facility administration.d. The supervisor will ensure that the resident(s) is/are protected from further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.g. An employee suspected of violation of the Resident Safety Abuse Policy or Social Media Policy may be suspended pending investigation. Example 1 On 11/15/25, NHA A (Nursing Home Administrator) was made aware of an allegation of abuse regarding R1 and CNA G (Certified Nursing Assistant). It is important to note that Surveyor requested the investigation regarding R1. Facility staff provided 3 handwritten interviews that did not include an interview time and/ or signature of interviewee. There were no additional interviews from residents or staff. RN F's interview is as follows: RN F reported to me that there was a situation with R1 and CNA G. Hskpr E says something about CNA G being mean to R1 and that she threw R1's legs in his w/c (wheelchair). His pantleg got stuck in his locks. He can't get it as, so CNA G tried to help but was frustrated because he was doing it all day. Ask RN F to talk with R1. Said they tossed my around- talked cub transfer? Hskpr E's statement is as follows: R1 needed help, so got CNA G. Talked about how his pant was stuck. CNA G yelled? Put his leg harshly on the wheelchair pedal. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525409	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine View Care Center	400 County Rd R Black River Falls, WI 54615

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA G's statement is as follows: Wasn't swearing at him, fighting against me and trying to help get his pant leg off the pedal. Asked him to stop moving. Was curt with him and frustrated because he wasn't listening. On 12/3/25 at 2:30 PM, Surveyor interviewed NHA A. Surveyor asked NHA A if they were aware of the allegation of abuse regarding R1 and CNA G, NHA A stated that they received a call about the incident and initiated an investigation. NHA A reported that they received a call from RN F reporting that Hskpr E reported an allegation of abuse, stating that CNA G was yelling and being rough with R1. Surveyor asked NHA A if that is an allegation of abuse, NHA A stated yes. Surveyor asked NHA A if they completed a complete investigation, NHA A stated yes. Surveyor asked NHA A if they interviewed other staff and residents, NHA A stated no. Surveyor asked NHA A if CNA G was suspended or removed from patient care during the investigation, NHA A stated no. Of note: there is no evidence protective measures were put in place to prevent further abuse from occurring. Example 2: R2 admitted to facility on 8/22/25 and has diagnoses that include atrial fibrillation (irregular heartbeat where the upper chambers of the heart quiver due to misfiring electrical signals) and hypertension (high blood pressure). R2's Grievance Report, dated 9/25/25, states, in part: .Describe the situation/issue/complaint: FM D (Family Member) expressed concern of the approach staff had with R2 while transferring her with the EZ stand. She stated they were abrupt with her and had an inappropriate way of communicating with her. Summary statement of resident's grievance: FM D of R2 states staff were using an inappropriate approach when transferring her sister. They made statements such as She was unmotivated, non-compliant, refusing cares and told R2 she could remain in chair. Facility provided interviews with R2, FM D, and 2 cnas (1 that worked with R2 that evening of concern. 1 cna that was not on shift the evening of concern). Surveyor reviewed the facility's education on Approach with Residents, dated 9/25/25, to nursing staff on approach with residents and various situations with different [sic], how to handle situations effectively. There are twenty-four nursing staff signatures. Surveyor reviewed education on Resident Rights/Safety & Abuse Policy, dated 10/09/25, to all staff on understanding approaches with residents and understanding how to go with different situations. Understanding resident rights after background. Resident safety & abuse. There were twenty-nine signatures. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/03/25, at 2:00PM, Surveyor interviewed NHA A (Nursing Home Administrator) and asked if she was aware of the incident with R2 and staff in September. NHA A indicated yes. Surveyor asked when NHA A became aware of the incident, and NHA A indicated that day, 9/25/25. Surveyor asked if a resident is told they can stay in the chair, go to the bathroom in the chair and sleep in the chair is an allegation of abuse. NHA A indicated yes. Surveyor asked if this incident was reported to the state. NHA A indicated the facility has two hours to investigate the allegation to determine if it was abuse and report to the state in two hours if it was. NHA A indicated she had not reported it to the state. Surveyor referred NHA A to the State of Operations Manual tag F609 and F610. Surveyor asked NHA A what the facility's process is for an allegation of abuse. NHA A indicated to investigate it, interview staff that are involved, complete skin checks, and interview staff. Surveyor asked if the facility completed a full investigation of the incident and NHA A indicated no. The facility did not complete a thorough investigation into allegations of abuse involving R1 and R2. The facility did not put protections in place to prevent further abuse from occurring from the staff involved.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that the resident environment remains as free of accident hazards as is possible for 1 or 3 residents (R3) reviewed for transfers.R3 was transferred using a sit-to-stand mechanical lift instead of a full body mechanical lift.This is evidenced by:The facility's policy Body Mechanics-Transfer Training, dated 11/24, includes: To provide direction to nursing staff members for training of appropriate body mechanics and safe resident transfer techniques. ii. If the resident has no ability to sit, stand, or bear weight, DON'T LIFT - use a mechanical assist.R3 admitted to the facility on [DATE]. R3 has a right below the knee amputation.R3's comprehensive care plan includes: 11/12/25 Transfer assist: Full body lift assist of 2.On 12/3/25 at 12:59 PM, Surveyor interviewed CNA H (Certified Nursing Assistant) regarding R3's transfers. CNA H indicated R3 is a full body mechanical lift per R3's care plan. CNA H indicated on 12/2/25 he used a sit-to-stand mechanical lift to transfer R3 instead of the care planned full body mechanical lift. CNA H indicated he should not have done that.On 12/3/25 at 1:06 PM, Surveyor interviewed NHA A (Nursing Home Administrator) regarding CNA H inappropriately transferring R3. NHA A indicated CNA H used a sit-to-stand mechanical lift instead of the full body mechanical lift. NHA A indicated she did educate CNA H regarding following the care plan and transfer training.