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	04/29/2026

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure residents have a right to be treated with respect and dignity, for 1 (R8) of 5 residents reviewed for resident rights.Certified Nursing Assistant (CNA) H searched through and removed items from R8's purse without permission while R8 was out of the room.Findings include:R8 was admitted to the facility on [DATE].On 04/13/26, R8's Minimum Data Set (MDS) assessment showed a Brief Interview for Mental Status (BIMS) score of 15/15 indicating R8 is cognitively intact.R8's diagnoses include aftercare following joint replacement surgery, hypertension, major depressive disorder, chronic pain syndrome, edema, and attention-deficit hyperactivity disorder.On 04/05/26, R8 reported Certified Nursing Assistant (CNA) H went through R8's purse while R8 was receiving a shower from CNA K. R8 reported CNA H removed Tylenol and other medications and had no business being in R8's purse. R8 reported R8's purse was in the nightstand tucked away, and R8 has no idea if CNA H took any other things.On 04/07/26, a progress note from Registered Nurse (RN) N stated: This writer stated we initially found the Oxy (Oxycodone) in R8's purse and that we cannot have residents with narcotics on their person in the building.On 04/28/26 at 8:48 AM, Surveyor attempted to call R8 but R8's phone went straight to voicemail. R8's voicemail box was not setup and Surveyor was unable to leave a message.On 04/29/26 at 10:53 AM, Surveyor interviewed CNA K about the day of the incident. CNA K stated CNA K gave R8 a shower but did not have any information about the events that occurred while doing so.On 04/29/26 at 12:18 PM, Surveyor interviewed RN N about R8's reported incident on 04/05/26. RN N stated R8's oxycodone prescription bottle from home was retrieved from R8 and placed in the medication cart for use. RN N stated RN N believed CNA H had removed it from R8's purse but did not know if CNA H had permission or where the purse was located.On 04/29/26 at 2:28 PM, Surveyor interviewed CNA H about the reported incident. CNA H stated a housekeeper had found a pill on the floor in R8's room and gave it to CNA H. CNA H stated CNA H showed it to a nurse and discovered it was not one that the facility supplied to R8. CNA H stated CNA H was told to go look through R8's room to see where it would have come from. CNA H stated CNA H found the medications in R8's purse which was on the nightstand. CNA H stated CNA H did not have permission to go through R8's belongings.On 04/29/26 at 3:05 PM, Surveyor interviewed Director of Nursing (DON) B about the reported incident on 04/05/26. DON B was unaware of the events and acknowledged CNA H should not have gone through R8's belongings without permission. DON B stated staff should have asked R8 to hand over the medications for safe keeping or send them home with family.

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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(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** Based on interview and record review, the facility did not have evidence that all alleged violations are thoroughly investigated which involved 2 (R6 and R7) of 7 residents reviewed for abuse.The facility did not implement immediate interventions, update care plans, or complete monitoring in relation to a resident-to-resident physical altercation between R6 and R7. Findings include:Facility Policy titled, Resident Safety and Abuse Policy, last revised 02/2022, states Residents have the right to be free from abuse by anyone, including, but not limited to, facility staff, other residents.This 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.All alleged violations will be thoroughly investigated.When cause or probable cause is determined, the resident care plan will be revised to ensure a corrective plan is in place to prevent recurrence.R7 was admitted to the facility on [DATE].On 04/28/26, R7's Minimum Data Set (MDS) assessment showed a Brief Interview for Mental Status (BIMS) score of 14/15 indicating R7 is cognitively intact. R7's diagnoses include right femur fracture, type 2 Diabetes Mellitus, muscle weakness, and history of falls.R6 was admitted to the facility on [DATE]. On 03/19/26, R6's Minimum Data Set (MDS) assessment showed a Brief Interview for Mental Status (BIMS) score of 6/15 indicating severe cognitive impairment. R6's diagnoses include atrial fibrillation, Parkinson's disease, major depressive disorder, anxiety, chronic kidney disease, and history of falls.On 04/13/26, the facility submitted a self-report regarding a resident-to-resident altercation between R6 and R7. The report stated that on 04/12/26, R7 was playing cards in the activity room with another resident during a televised church service which R6 thought was disrespectful. R6 went to remove cards and R7 slapped R6's hand away. The report stated R7 and R6 agreed to distance themselves from each other, and R6 agreed R6 should not have attempted to remove the cards. The report stated R6 has no injury and no ill effect. The final report stated R6 stated it was just a misunderstanding and R6 feels safe at the facility.Surveyor reviewed R6's Electronic Health Record (EHR) and noted there was no monitoring in place in relation to the incident on 04/12/26 and regarding R6's statement to Director of Social Services (DSS) E about being scared.Surveyor reviewed care plans for R6 and R7 and noted no updates/interventions were added to R6 and R7's care plans to prevent reoccurrence following the incident on 4/12/26. On 04/29/26 at 11:55 AM, Surveyor interviewed R7 about the incident on 04/12/26. R7 stated R6 can be bossy at times and didn't like that I was playing cards during the church service. R7 stated R6 came over and ruffled up the cards so I cuffed her hand away. Surveyor asked R7 if anyone spoke with R7 after the incident about how to prevent it from happening again. R7 stated that no one had spoken to R7 and that R6 and R7 were getting along fine now. R7 stated R7 has not had any further issues with R6.On 04/29/26 at 12:08 PM, Surveyor interviewed R6 about the incident on 04/12/26. R6 stated the incident is a silly little thing that everyone is making a big deal of. R6 stated it was a little slap that did not leave any marks. Surveyor asked R6 about the statement R6 made to DSS E about being scared. R6 stated that at first R6 was scared because it caught R6 off guard, and then R6 was scared that R6 did something wrong and was afraid R6 would get kicked out of the facility. R6 stated R6 and R7 have had no further concerns.On 04/29/26 at 12:14 PM, Surveyor interviewed Registered Nurse (RN) G about what to do if RN G observes or is informed of physical altercations between residents. RN G stated first RN G would separate the two residents and inform Director of Nursing (DON) B. RN G stated RN G would fill out an incident report and that DON B would guide RN G on what to do next. RN G stated RN G would also maintain the safety of the residents.On 04/29/26 at 3:05 PM, Surveyor interviewed DON B about the follow up and investigation process of the incident on 04/12/26. DON B acknowledged no interventions/updating of care plans to prevent further incidents between R6 and R7.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility did not revise 1 (R8) of 12 comprehensive care plans and include person-centered, comprehensive interventions.R8's comprehensive care plan was not updated with person centered interventions.Findings include:R8 was admitted to the facility on [DATE]. On 04/13/26, R8's Minimum Data Set (MDS) assessment showed a Brief Interview for Mental Status (BIMS) score of 15/15 indicating no cognitive impairment. R8's diagnoses include aftercare following joint replacement surgery, hypertension, major depressive disorder, chronic pain syndrome, edema, and attention-deficit hyperactivity disorder.Surveyor reviewed R8's baseline care plan dated 04/02/26 which indicated R8 was a stand and pivot transfer and was continent of bladder.Facility-reported incident report stated that on 04/03/26, R8 reported that Certified Nursing Assistant (CNA) F told R8 to go to the bathroom in R8's incontinent product. R8 told CNA F that R8 would not do that and ultimately CNA F did assist R8 to the bathroom. The report stated that CNA F could not find a bedpan and CNA F was concerned about R8's pain during a transfer as R8 had been recently admitted after a hip replacement. The report indicated R8 was upset by the situation. CNA F was suspended pending investigation. Surveyor reviewed R8's baseline and comprehensive care plans and noted no new interventions were put in place immediately after the reported incident on 04/02/26.On 04/28/26 at 10:04 AM, Surveyor observed no bedpans in the supply closet on the 100 hall medication room, or in either shower room on the memory care unit.On 04/28/26 at 5:38 PM, Surveyor interviewed CNA F about the incident on 04/02/26. CNA F stated the facility did not have a care plan ready and there were no bedpans available. CNA F stated R8 was screaming in pain and CNA F was hesitant to stand R8 because of the pain. CNA F stated that CNA F did not get report on R8 and how R8 transfers. CNA F reported that CNA F told R8 that if R8 was unable to wait for CNA F to find a bedpan or how R8 transfers, then R8 could just go in R8's brief if need be. CNA F reported CNA F was not trying to upset R8 or be mean in any way.On 04/29/26 at 10:20 AM, Surveyor interviewed CNA J regarding following care plans. CNA J stated CNA J would follow the care plan for instructions on how to transfer a resident, and that the care plans are created and available to staff the day of admission.On 04/29/26 at 12:14 PM, Surveyor interviewed Registered Nurse (RN) G about care plans. RN G stated a nurse is assigned to take report from the facility the resident is discharging from prior to admission to this facility. RN G stated the baseline care plan is created and available at the nurse's station upon admission and the CNAs have access to it. RN G stated the nurses also give CNAs verbal report on residents.On 04/29/26 at 2:28 PM, Surveyor interviewed CNA H about transfer status of residents. CNA H stated the transfer status is found on the care plan which is made as soon as a resident is admitted . CNA H stated the bedpans are most often in the main supply closet and reports that some staff assume there aren't any if they aren't found in the small supply closet on the 100 hall. CNA H stated that some staff just don't want to walk down to the main supply closet to get them.On 04/29/26 at 3:05 PM, Surveyor interviewed DON B (Director of Nursing) about information available to staff regarding new admissions. DON B stated the care plan is started right at the time of admission and includes information such as transfer status, diet, bowel and bladder information, and shower information. DON B stated this information would be available to staff on the care plan and CNA care cards. DON B stated the nurse would get report from the other facility and the transfer status of a new admission would be known prior to the resident's arrival to the facility.On 04/29/26 at 3:20 PM, Surveyor interviewed DON B about the education and interventions related to the incident on 04/02/26. Surveyor asked DON B, as part of the interventions for the incident, only 9 nursing staff were educated. DON B stated education was ongoing, and they catch staff as they come in. DON B acknowledged no immediate interventions were placed in R8's care plan and the education was not complete.

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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 each resident receives adequate supervision and assistance devices to prevent accidents for 1 (R9) of 3 residents reviewed for accidents.The facility staff did not follow R9's care plan for transfer status. R9 is a Hoyer lift and staff utilize the sit-to-stand mechanical lift for transfers.Findings include:The facility policy titled, Resident Assessment Instrument and Person-Centered Care Planning, last reviewed on 04/2025, states: The Resident Assessment Instrument (RAI).is to be completed by the Interdisciplinary Team (IDT).to identify the strengths, goals, life history and preferences of the resident to develop a person-centered care plan, to provide the appropriate care and services for each resident and to modify the care plan and care/services based on the resident's status.R9 was admitted to the facility on [DATE].On 02/25/26, R9's Minimum Data Set (MDS) assessment showed a Brief Interview for Mental Status (BIMS) score of 3/15 indicating severe cognitive impairment.R9's diagnoses include Alzheimer's dementia, coronary artery disease, hypertension, and peripheral vascular disease.Surveyor reviewed R9's ADL (activities of daily living) care plan, dated 11/11/25, states in part . R9 transfers via Hoyer lift and assist of 2. Toileting requires assistance of 2.Of Note: R9's toileting indicates assistance of 2 but does not indicate what equipment is used for the transfer.On 04/29/26 at 10:08 AM, Surveyor attempted to interview R9 in relation to transfers. R9 was unable to answer questions due to R9's impaired cognition.On 11/18/25 at 11:18 AM, Surveyor interviewed Family Member (FM) M about R9's transfers. FM M stated FM M believed the staff used the sit-to-stand mechanical lift to place R9 on the commode/toilet. FM M was not aware of improper transfers, but stated staff had better be using what is ordered.On 04/29/26 at 12:18 PM, Surveyor interviewed Registered Nurse (RN) N about R9's transfer status. RN N stated R9 was supposed to be a Hoyer lift for all transfers, but that staff did use the sit-to-stand lift for toileting. RN N stated they were talking with Hospice about getting an order to use the sit-to-stand lift just for toileting but had not gotten the official order yet.On 04/29/26 at 2:28 PM, Surveyor interviewed CNA H about R9's transfer status. CNA H stated the Hoyer lift is used for transferring R9 in and out of bed/wheelchair and the sit-to-stand is used for toileting. CNA H stated it's CNA H's understanding this is what was ordered per Hospice.On 04/29/26 at 3:05 PM, Surveyor interviewed Director of Nursing (DON) B about R9's transfer status. DON B stated DON B believed staff used the Hoyer lift for transfers but the sit-to-stand for toileting and this was arranged with Hospice. DON B did state the care plan stated R9 was a Hoyer lift and there was no current order to use the sit-to-stand lift for any transfers.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and record review, the facility did not ensure it had procedures in place to assure the accurate acquiring, receiving, dispensing, and administration of all drugs and biologicals to meet the needs of each resident or contacting the provider when a resident's medication(s) is not available for administration for 1 of 4 residents (R3).R3 was noted to have not received scheduled doses of ASA (aspirin), Bupropion, Famotidine, Fluticasone salmeterol inhaler, Amitriptyline, and Duloxetine. The facility policy titled Medication/Treatment Administration Error Policy last revised on 04/25, states: Protocol (1)(b): A facility medication/treatment error occurs when a prescribed medication is not available to be administered. Protocol (2)(f) A pharmacy medication error occurs when: a drug is unavailable from the pharmacy that the physician prescribed. Protocol (3) immediately upon discovery of a medication/treatment error, the nurse completes the top section of the Medication/Treatment Error Administration Report and turns it in to the director of nursing or administrator within 24 hours R3 was admitted to facility on 03/18/26 with diagnosis' that included atrial fibrillation, major depressive disorder, asthma, and had a physician order for the following medications: On 04/28/26, Surveyor reviewed R3's admission medication record and noted that R3 did not receive the following prescribed medication: *Aspirin 81 mg one time a day. R3 had 3 missed doses of scheduled Aspirin. *Bupropion HCl ER 300mg one time daily. R3 had 2 missed doses of scheduled Bupropion. *Famotidine 40mg daily. R3 had 3 missed doses of scheduled Famotidine. * Fluticasone salmeterol inhaler twice daily. R3 had 11 missed doses of scheduled Fluticasone salmeterol inhaler. *Amitriptyline 25 mg one time daily. R3 had 3 missed doses of scheduled Amitriptyline. *Duloxetine 60 mg one time daily. R3 had 3 missed doses of scheduled Duloxetine. On 04/28/26, Surveyor reviewed facility incident logs; no identified medication errors noted on incident log. On 04/28/26, the Surveyor reviewed R3's progress notes. Notes did not reveal there had been any physician notification of medications being unavailable to the facility.On 04/29/26 at 7:36 AM, Surveyor interviewed Nursing Home Administrator (NHA) A regarding R3 not receiving admission medications for several days and the physician not being contacted regarding the medication not being available. NHA A stated was not aware of R3 not receiving medication and stated the expectation would be that the physician would be contacted for further direction/orders.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on interview and record review, the facility did not ensure it had procedures in place to assure the accurate acquiring, receiving, dispensing, and administration of all drugs and biologicals to meet the needs of each resident or contacting the provider when a resident's medication(s) is not available for administration for 1 of 4 residents (R3).R3 was noted to have not received scheduled doses of Xarelto (anticoagulant) and Amiodarone.The facility policy titled Medication/Treatment Administration Error Policy last revised on 04/25, states: Protocol (1)(b): A facility medication/treatment error occurs when a prescribed medication is not available to be administered. Protocol (2)(f) A pharmacy medication error occurs when: a drug is unavailable from the pharmacy that the physician prescribed. Protocol (3) immediately upon discovery of a medication/treatment error, the nurse completes the top section of the Medication/Treatment Error Administration Report and turns it in to the director of nursing or administrator within 24 hours R3 was admitted to facility on 03/18/26 with diagnosis' that included atrial fibrillation, major depressive disorder, asthma, and had a physician order for the following medications: On 04/28/26, Surveyor reviewed R3's admission medication record and noted that R3 did not receive the prescribed significant medication: *Xarelto (anticoagulant) 20mg every evening. R3 had 5 missed doses of scheduled Xarelto. *Amiodarone 200 mg three times a day. R3 had 8 missed doses of scheduled Amiodarone. On 03/19/26 at 6:21 pm, the facility entered a nursing progress notes indicting R3's Xarelto was held due to being unavailable. On 04/28/26, Surveyor reviewed facility incident logs; no identified medication errors were noted on incident log. On 04/28/26, the Surveyor reviewed R3's progress notes. Notes did not reveal there had been any physician notification of medications being unavailable to the facility.On 04/29/26 at 7:36 AM, Surveyor interviewed Nursing Home Administrator (NHA) A regarding R3 not receiving admission medications for several days and the physician not being contacted regarding the medication not being available. NHA A stated was not aware of R3 not receiving medication and stated the expectation would be that the physician would be contacted for further direction/orders.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on interview and record review, the facility did not ensure dietary staff had the appropriate competencies and skill sets to carry out the functions of the food and nutrition services. This had the ability to affect all 32 residents.Facility Cook's son, who is not an employee of the facility, was assisting with kitchen duties.The Division of Quality Assurance received concerns indicating [NAME] C was taking pictures in the facility kitchen and posting them on social media on 03/30/26 and photo evidence was provided. The photo contained a caption that read, Thank you Jesus for my son coming to work with me through this dbl . to help his mom out!! . The post showed identified son handling beverages. Surveyor reviewed [NAME] C's social media page and confirmed the photos and captions were still present and open to the public. Surveyor attempted to contact [NAME] C and was unsuccessful.The facility employee handbook Page 5 states in part . all employees will be required to submit a two-stage TB test upon hire. Page 9 states in part . that people are hired on a trial basis for the purpose of assessing abilities to perform assigned tasks and will receive a 6-month orientation period. Page 16 states in part . all visitors should enter the facility at the reception area, receive directions or be escorted to their destinations. Employees are responsible for the conduct and safety of their visitors. Page 19 states in part . all employees will have a personnel file including name, address, phone number, emergency contact, any physical or other limitations, tax and insurance forms, training, education, and undergo reference checks,On 04/28/26 at 9:48 AM, Surveyor visited the facility kitchen and was able to identify where the picture was taken with the whiteboard, door, and refrigerator in the background. At 9:52 AM, Dietary Manager (DM) D entered the kitchen. Surveyor asked if [NAME] C was a current employee. DM D replied, Yes. Surveyor asked if any of Cooks C's children were employed or volunteered in the kitchen. DM D stated they were not; however, the son comes in every so often to visit his mom and it is allowed if wearing a hair net and stays in the back of the kitchen near the exit door. DM D added that visitors are not allowed to touch any food. Surveyor showed DM D the social media picture of a visitor (identified as [NAME] C's son) actively working, handling pitchers of beverages near the counter in the kitchen. DM D verbalized no knowledge of that happening, it is not acceptable, and will educate [NAME] C. On 04/29/26, Surveyor met with Nursing Home Administrator A and two corporate employees to inform them of the above concern. They also reviewed and confirmed the posting on [NAME] C's social media page, appeared very surprised, assured the issue will be addressed, and thanked Surveyor.