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	03/28/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 30570 Based on observation, interview and record review, the facility did not assist 1 of 13 sampled and supplemental residents (R19) with eating in a dignified manner by scooping food from her lip and chin with a spoon and feeding it to her. This is evidenced by: Surveyor requested and received the facility policy titled Meal Service Standards which is dated as last revised on 12/18. The policy in part reads: Purpose: The following meal service standards will ensure our residents have a safe, pleasant and enjoyable dining service. Protocol: 1. Dignity: h. All residents are served in a dignified and courteous manner. Surveyor reviewed R19's record and noted the following: The most recent quarterly Minimum Data Set (MDS) completed 12/28/24 notes R19 is dependent on staff to eat. On 3/26/24 at 12:49 PM, Surveyor observed Certified Nursing Assistant (CNA) E sitting at dining room table between R19 and another resident. R19 was faced away from the table in the wheelchair and CNA E was seated at table with her lunch tray. CNA E alternated bites of food that was pureed and drinks of beverages using a glass with a straw. CNA E wiped food from R19's lower lip and upper chin with spoon that she was using to feed resident. CNA E fed R19 the food from her lip and chin. Surveyor observed CNA repeat the swiping food from R19's lower lip and chin with her spoon several times and feeding R19 the food. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/27/24 at 8:04 AM, Surveyor observed breakfast in the dining room. CNA E placed R19 at the same table in the same manner as observed for lunch on 3/26/24. CNA E sat at table at R19's side. CNA E was brought R19's breakfast tray of eggs, hot cereal and beverages. CNA E applied a cloth napkin under R19's chin and began feeding her the scrambled eggs and cereal. CNA E alternated feeding R19 and another resident at the table. Surveyor observed CNA E wipe food that was dripping from R19's lip and chin with a spoon and feeding it to her 11 times while assisting her to eat. CNA E did not use the cloth napkin that was placed under R19's chin to wipe the food from R19's lower lip or chin. On 03/27/24 at 2:01 PM, Surveyor spoke with CNA E about the observation. CNA E indicated she works 3 days a week and assists R19 with her meal each day CNA E works. CNA E expressed CNA E has never been told not to use a spoon to wipe food from resident faces and refeed it to them. CNA E further expressed not being aware it is not dignified to do so and frequently clears food from R19's face as Surveyor observed. On 3/27/24 at 3:00 PM, Surveyor spoke with Director of Nursing (DON) B about the observation. DON B explained it is not appropriate for staff to wipe residents' chins or lips with a spoon and re-feed them due to dignity and infection control reasons. DON B indicated staff reeducation will be initiated.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46693 Based on observation, record review and interviews, the facility did not ensure that 1 of 3 sampled and supplemental residents (R) who are unable to carry out activities of daily living received the necessary services to maintain good nutrition (assistance with meals). (R9) Findings include: R9 was admitted to the facility on [DATE], with diagnoses including Alzheimer's disease, dementia with anxiety, irritability and anger, depression, chronic diarrhea, peripheral vascular disease, osteoarthritis, and hypertension. R9's Minimum Data Set (MDS) assessment, completed on 01/12/24, confirmed R9 scored 01 during a Brief Interview for Mental Status (BIMS), indicating severely impaired cognition. R9 had weight loss and requires set-up assistance with eating. R9 requires substantial maximal assistance from staff for dressing and is dependent on staff for bathing, toileting, and transfers. R9's care plan was initiated on 10/14/23, and included the following: R9 is at nutritional risk due to dementia, forgets to drink with cup and needs reminders. Interventions include remind to drink out of cup at meals, set-up and assist resident as needed, and offer substitutes if more than 50% of food is left uneaten. Speech therapy recommendations dated 10/30/23, notes Provide verbal cues and physical assist during meals to continue eating and for safety, provide feeding assist if not initiating or discontinues on her own. Surveyor reviewed weights and noted: R9 lost 19.8 pounds which is a 9.17% loss in 5 months while residing at the facility. Observations were continuous from 03/26/24 at 12:25 PM to 03/26/24 at 1:09 PM. On 03/26/24 at 12:25 PM, R9 received the lunch tray which consisted of 4oz juice, 8oz milk, bread, ham, scalloped potatoes, peas, and cake. R9 wheeled up to the table, picked up the spoon, licked it, then picked up ham with fingers and ate it. R9 then took juice and poured it over the meal. Registered Nurse (RN) G offered to help and R9 said no, then RN G left. R9 then fed self peas and ate bread soaked with juice. R9 placed the spoon in the cup of milk and tried to drink it like a straw. R9 ate a huge bite of cake and then placed the fork in the milk. Unsuccessfully, R9 tipped up small bowl with a few cake crumbs in it and tried to eat it. At 1:01 PM, RN G stated quietly, Oh we are going to eat with juice today, then assisted R9 back to the table, cued her to eat, handed R9 a fork with potatoes on it, then walked away. R9 did not eat the potatoes but drank 2 oz of juice independently and no milk. At 1:09 PM, R9's tray was picked up and placed on the cart. R9 did not drink milk and ate the cake, 3 bites of ham, and one spoon of peas of which most fell off the spoon and landed on the floor. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed R9's meal ticket that noted: Special instructions: Finger foods. Dislikes oatmeal. Lunch drinks 8oz milk and 4oz juice. Staff did not offer fluids, did not replace food soaked in juice, did not offer finger foods or alternative foods, and only one attempt at physical assistance to eat was made in the 44 minutes R9 had her lunch tray. Only 2 staff were in the dining room, and they were assisting 6 residents. Observations were continuous from 03/27/24 at 7:51 AM to 03/27/24 at 9:10 AM. On 03/27/24 at 8:03 AM, R9 was brought to dining room via wheelchair by Certified Nursing Assistant (CNA) H and was provided with breakfast. Breakfast included: Scrambled eggs, toast, cheerios, 8oz milk 4 oz juice. R9 was falling asleep at the table. At 8:10, R9 scooted away from table/breakfast. At 8:22 AM, CNA H checked on another resident at same table as R9 but did not offer or assist R9. R9 remained sitting approximately 5 feet away from the table/meal. At 8:30 AM (27 minutes after receiving her meal), CNA H approached R9 and verbally cued R9 to move to the table to eat. R9 scooted self to the table and was scraping toast with a spoon, then took spoon and moved food around on the tray but did not take any bites. R9 then put the spoon back on the tray. At 8:33 AM, R9 picked up the spoon and stirred the cereal. At 8:36 AM, CNA H applied glasses to R9 and walked away without cueing or assisting with the meal. At 8:40 AM, CNA H offered and provided R9 with coffee, setting it on the table, then tried to move R9 back to the table. R9 put feet down to avoid being brought to the table. A few minutes later, R9 moved to the table and looked at the meal. At 8:42 AM, CNA H cued R9 to eat as she walked past R9 and told Licensed Practical Nurse (LPN) I that R9 is more sleepy in the mornings lately and R9 likes jelly on her toast. At 8:44 AM (41 minutes after receiving meal), LPN I put jelly on R9's toast, handed it to R9 who ate the 1/2 piece. R9 then took a bite of cereal on her own then stopped feeding self. On 03/27/24 at 8:54 AM, Surveyor interviewed LPN I what the approaches were for R9 during meals. LPN I stated that R9 will eat when she wants and it depends on her mood. LPN I said, I tried to feed her yesterday and she slapped me. Surveyor asked what R9 would do if handed drinks, which LPN I said R9 will set it back down or throw it at us. At 8:57 AM (almost an hour after receiving her tray), LPN I handed her the other half of jelly toast and R9 ate it. At 8:59 AM, Surveyor noted the limited assistance for R9 and asked LPN I to hand R9 the milk to see how R9 responds. LPN I handed the milk to R9 who took it in her hand and guzzled the whole 8 ounces at one time. No other foods or drinks were offered. Tray was removed at 9:10 AM. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R9 was not assisted timely on 03/27/24 with the breakfast meal or to the extent required. The meal was not reheated. Additional fluids or finger foods were not offered for a resident with severe cognitive impairment and weight loss. On 03/27/24 at 9:50 AM, Surveyor interviewed Certified Dietary Manager (CDM) C who stated, I am aware of the weight loss for R9. We monitor weights, provide finger foods, and send double breakfasts since she likes breakfast. R9 likes jelly toast and sweets. We send both finger foods and regular meals because R9 sometimes will eat regular food. Surveyor informed CDM C of observations, and CDM C stated she was not aware and will provide cups with lids and straws for R9. Surveyor reviewed Registered Dietitian notes dated 10/14/23 and noted that R9 needs direction and drinks 240-360cc/day and estimated needs are 1650-1980cc/day. Assessed again on 11/14/23 and noted decreased intake and poor appetite resulting in a 7.8% weight loss in 90 days and has no chewing or swallowing concerns. On 03/27/24 at 10:10 AM, Surveyor interviewed Speech Therapist (ST) J. ST J stated she treated R9 from 10/30/23 to 11/06/23 and there were no concerns with swallowing or chewing and worked mostly with R9's attention span. On 03/27/24 at 1:36 PM, Surveyor interviewed DON B and RN K. Surveyor asked what would be expected from staff when a resident with dementia continues to move away from the table and stops eating. RN K stated it would be expected to encourage the resident to eat, try finger foods and other snacks later. Surveyor explained the concern with R9 noted above. DON B stated they will educate right away and get right on that. RN K stated she will provide any education and interventions they are able to complete by tomorrow.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30570 Based on record review and interview, the facility did not comprehensively assess 1 of 2 residents (R31) for trauma informed care and care plan approaches to mitigate any triggers to prevent re-traumatization. This is evidenced by: Surveyor requested and received the facility policy titled Providing Culturally Competent and Trauma-Informed Care dated as most recently revised on 8/22. The policy in part reads: Purpose: Residents who are trauma survivors will receive culturally competent, trauma informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. Protocol: 1. Assessment: a. A multi-faceted approach to identifying resident history of trauma as well as his or her cultural preferences will be utilized. This includes asking the resident about triggers that may be stressors or may prompt recall of previous traumatic event; as well as screening and assessment tools such as the Resident Assessment Instrument, Admission Assessment, history and physical, the social history/assessment, and other assessment such as the PTSD-Civilian Screening Checklist and Life Events Checklist in ECS. 2. Recognizing and Assessing Trauma: a. Residents may be trauma survivors such as military veterans . b. Residents with a history of trauma may have diagnosis such as anxiety, depression or may have substance abuse issues such as alcoholism .Evidence of physical and/or psychological trauma can be reveled during a comprehensive .assessment 3. Recognizing and Assessing Triggers: a. The facility will attempt to identify triggers which may re-traumatize residents with a history of trauma. A trigger is a psychological stimulus that prompts stimulus that prompts recall of a previous traumatic event, trauma .For many trauma survivors, the transition to living in an institutional setting and associated loss of independence can trigger profound re-traumatization . 4. Care Planning to Address Past Trauma: a. The facility will collaborate with resident trauma survivors .to develop and implement individualized interventions . (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e. Trauma-specific interventions should also recognize the interrelation between trauma and symptoms of trauma such as substance abuse .depression .anxiety. On 03/26/24 at 10:25 AM, Surveyor spoke with R31 about mood and past trauma. R31 was calm and able to hold conversation. R31 reported no concerns with his mood at this time as R31 has plans to discharge home soon. R31 indicated issues with his mood in the past with alcohol dependence and sleep issues. R31 expressed he is a military veteran of the Vietnam war. Surveyor asked R31 if anyone from the facility has spoken with him about his history and anything that may cause him stress and how to avoid any re-traumatization. R31 indicated he could not recall anyone from the facility speaking with him about his history and things that may cause him stress. Surveyor reviewed R31's record and noted he was admitted [DATE] from Veteran's Association hospital. R31's diagnoses include post-traumatic stress disorder, alcohol dependence in remission, bipolar disorder, current episode depressed, mild or moderate severity, unspecified, adjustment disorder with depressed mood, primary insomnia, dysthymic disorder (persistent depressive disorder). Surveyor reviewed R31's Significant Change In Status Minimum Data Set (MDS) dated [DATE] which notes he understands, is understood and is cognitively intact. R31 has depressed mood indicators and no behavioral concerns. Surveyor reviewed R31's record and no trauma informed assessment was located. Surveyor reviewed R31's care plan and noted no trauma informed approaches to mitigate any retriggering of R31's past trauma. On 3/27/24 at 2:55 PM, Surveyor spoke with Assistant Nursing Home Administrator (ANHA) F, who took over social services responsibilities in February 2024 on an interim basis. ANHA F explained the facility process is to conduct a comprehensive trauma informed assessment when residents are admitted with diagnosis of PTSD or past trauma such as serving in a war. The assessment would determine if a care plan should be developed to address any triggers such as loud noises or bright lights that may cause stress to individuals. ANHA F indicated a comprehensive assessment was not completed with R31 thus no care plan was developed. ANHA F further expressed ANHA F had a conversation with R31 at some point about the diagnosis and any potential triggers. ANHA F could not recall when the conversation took place but recalled R31 indicated R31 was a veteran of the Vietnam war and did not indicate any triggers during the conversation; however, a comprehensive assessment was not completed. Surveyor requested a copy of the note of her conversation with R31 to determine what was discussed with R31 as Surveyor could not locate a note of the discussion in R31's record.

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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. 17661 Based on observations and interviews, the facility did not provide pharmaceutical services to meet the needs of 1 of 1 resident reviewed for insulin administration (R31). This is evidenced by: The Bureau of Quality Assurance issued a memo dated 9/23/2003 (Memo number 03-014) which states that insulin is classified into five categories: Rapid-acting, Short-acting, Intermediate-acting, Long-acting, and Combination products. The memo points out that Rapid-acting, Short-acting, and Combination products start working within a short time frame and are meant to control blood sugar levels at meals. The memo states that it is important that the meal and administration of the insulin are properly timed to optimize blood sugar control. The memo also states that rapid-acting insulins (Novolog and Humalog) should be administered 0-15 minutes before meals or immediately following a meal. Drugs.com states in relation to meal service with Insulin Aspart: .Insulin Aspart (Novolog): Administer subcutaneously within 5 to 10 minutes before a meal . On 3/27/24 at 6:57 AM, Surveyor observed Registered Nurse (RN) G measure R31's blood sugar, which recorded as 113. At 6:59 AM, RN G administered 10 units of Insulin Aspart (Humalog) to R31's right arm. R31 was observed by Surveyor until 7:57 AM, when he began to eat his meal. There were no offers until this time for juice, milk or any snack. This was 58 minutes after the insulin was given. On 3/27/24 at 3:00 PM, Surveyor interviewed RN G regarding her knowledge of administration of rapid-acting insulin. RN G stated, Well, it's a short-acting. I thought the meal was going to be around 7:30. Generally I would have given it closer to the meal. He was low (blood sugars). But, yes, I should have made sure it was closer to the meal. Surveyor then explained that because R31's blood sugars were low, diligence in regard to meal service and insulin administration should have been practiced. On 3/27/24 at 4:02 PM, Surveyor interviewed Director of Nursing (DON) B regarding the expectation of nurses administering rapid-acting insulin. DON B stated that her expectation is that The nurse should administer it within 5-10 minutes of a meal or right after. Surveyor then explained the observation made above. DON B stated, I will get right on this with education.