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	07/03/2024

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47807 Based on interview and record review, the facility did not formulate an advance directive for the resident. Resident (R) 185 did not have orders for the advanced directive they elected for on file, or in a place for emergency personnel to retrieve the information if needed. This had the ability to effect 1 of 13 residents surveyed (R185). Findings include: The facility policy, entitled Cardiopulmonary Resuscitation (CPR) or Do - Not - Resuscitate (DNR) Orders, dated [DATE], states: 1. Upon Admission, the licensed nurse of social worker will discuss the options, CPR or DNR and any other advanced directives with the resident and/or legal representative and received the corresponding physician orders. The Physician Order Summery (POS) is the designated place in the medical record for staff to record/find the CPR/DNR designation for each resident. R185 was admitted on [DATE] to the facility and is able to be understood by peers and understands. On [DATE], record review of R185's hard charts and electronic record could not produce an order for a Cardiopulmonary Resuscitation (CPR) or Do - Not - Resuscitate (DNR). Surveyor could not find a Provider Orders for Scope of Treatment form on file for R185. On [DATE] at 10:26 AM, Surveyor interviewed Registered Nurse (RN) C regarding the process for determining if a person was designated a CPR or DNR. RN C said they would look at the resident's most recent signed orders in the hard charts that were located at the nurse's station. They look at the orders because they are the most up to date source of information regarding the resident's designation for care. On [DATE] at 10:49 AM, Surveyor reviewed the hard charts again and did not find any doctor orders regarding CPR or DNR designations. Surveyor did not find the POST in the hard charts. (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 2:19 PM, Surveyor interviewed Quality Consultant (QC) D, regarding the process and missing orders for R185. QC D said the normal process if someone were to need CPR or DNR services would be for staff to look at the hard chart physician orders. If the orders were not signed yet they would have something printed out and on file that looks like the signed orders. QC D and other staff members looked for the orders in the hard charts and in the electronic medical record and could not locate the orders for a DNR. There were orders from the hospital that indicated the resident was a DNR, but these were not accessible to staff who would need them. QC D agreed the orders for the DNR were not accessible, and they would not expect staff to look at the hospital transfer paperwork that was in a different area in the hard charts for a DNR designation. QC D would expect the order sheet be placed in the binder so that staff know where to look in the case of an emergency. QC D, after conversation with Surveyor, contacted the hospital that R185 transferred from and asked for signed orders for the DNR to be placed as soon as possible in the hard charts.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 40181 Based on observation, interview and record review, the facility did not ensure a medication error rate of 5% or less. During the medication administration task, Surveyor observed 2 errors out of 27 medication opportunities, resulting in an error rate of 7.41%. This affected 1 of 4 residents (R17) observed for medication administration. R17 received two insulin injections by using injectable pens that a safety check was not completed on to ensure the injectable pens were dispensing insulin before administration. Findings include: Manufacturer's instructions for Basaglar Kwikpen (insulin glargine) state in part.Priming your pen: Priming means removing the air from the Needle and Cartridge that may collect during normal use. It is important to prime your Pen before each injection so that it will work correctly. If you do not prime before each injection, you may get too much or too little insulin. Step 6: To prime your Pen, turn the Dose Knob to select 2 units. Step 7: Hold your Pen with the Needle pointing up. Tap the Cartridge Holder gently to collect air bubbles at the top. Step 8: Continue holding your Pen with Needle pointing up. Push the Dose Knob in until it stops, and 0 is seen in the Dose Window. Hold the Dose Knob in and count to 5 slowly. You should see insulin at the tip of the Needle. If you do not see insulin, repeat the priming steps, but not more than 4 times. If you still do not see insulin, change the Needle and repeat the priming steps . On 07/02/24 at 8:13 AM, Surveyor observed Registered Nurse (RN) C take two insulin pens out of the medication cart and attach needles to the end of each pen. RN C verified the pens with the orders on the Medication Administration Record (MAR) for R17. One pen was Insulin Glargine 100 units/milliliter (ml) with orders to administer 9 units by subcutaneous (sub-Q) injection daily. The other pen was Insulin Aspart 100 units/ml with orders to administer 3 units sub-Q twice per day. Surveyor observed RN C turn the dose knob to 9 on the Insulin Glargine pen. Surveyor observed RN C turn the dose knob to 3 on the Insulin Aspart pen. RN C did not prime either pen prior to selecting the prescribed dose. RN C carried both pens to R17's room and administered both injections into R17's abdomen per procedure. Immediately following the procedure, Surveyor interviewed RN C and asked if they primed the needles on the insulin pens prior to setting the pens to the prescribed dose. RN C stated they had never been taught that and didn't know they were supposed to do that prior to administering insulin with a pen injector. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/02/24 at 8:28 AM, Surveyor interviewed Director of Nursing (DON) B about the policy and procedure for use of insulin pens. DON B was not sure they had a specific policy and procedure for insulin pens and was not sure if insulin pens required priming of the needle prior to administering the dose. DON B stated they follow the manufacturer's instructions for insulin pens. DON B stated they would provide the manufacturer's instructions and facility policy, if they had one, for Surveyor to review. On 07/02/24 at 8:46 AM, DON B provided the manufacturer's information for the insulin pens and stated RN C did not follow the proper procedure for priming the insulin pens prior to administering insulin to R17. DON B stated they would provide education about the proper procedure to RN C and all nursing staff.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47807 Based on observation, interview and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety. The facility did not ensure that potentially hazardous foods were served at temperatures that would reduce the chance of illness for residents. The facility did not cover food while transporting room trays past resident rooms and in hallways. This has the potential to affect 2 residents (R) (R1, R12) on a pureed diet and 3 of 8 residents (R6, R17, R5) receiving room trays. Findings include: The facility policy entitled, Food Temperatures, dated January 2024, states in part, 4. Take temperatures a. Cooking temperatures must be reached and maintained according to regulations, laws and standardized recipes while cooking . 5. The food service manager will a. review logs daily to ensure that appropriate temperatures are recorded and corrective actions are being taken. b. take corrective action as necessary. The facility policy entitled, Food Temperature Log, dated May 2024, states in part, HOT HOLDING: Typical serving temperature standards . All hot foods should be held at 140 degrees Fahrenheit or above On 07/02/24 at 8:09 AM, Surveyor observed a tray of food delivered to R6. On the tray was a bowl of cereal that had no covering and was exposed. Licensed Practical Nurse (LPN) E delivered the tray walking approximately 100 ft past three other resident rooms with the uncovered food. On 07/02/24 at 8:11 AM, Surveyor observed a tray of food delivered to R17. On the tray was a bowl of cereal, juice, and coffee that had no coverings and was exposed. LPN E delivered the tray walking approximately 50 ft past activity room where residents frequently are and shower room. On 07/02/24 at 8:15 AM, Surveyor observed a tray of food delivered to R5. On the tray was a bowl of oatmeal, juice, and milk that had no covering and was exposed. LPN E delivered the tray walking approximately 80 ft past one other resident room and offices with the uncovered food. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/02/24 at 11:50 AM, Surveyor observed food being served for service in the kitchen. During observation Dietary Aide (DA) G was taking temperatures of all foods on the steam table. One item, the pureed lasagna, was checked and the temperature read 128 degrees Fahrenheit. DA G reported that temperature to Dietary Manager (DM) F who recorded the temperature in their logbook and service continued. The pureed lasagna was not reheated and stayed in the steam table. The first pureed diet to be dished was for R12, and when they were making the tray, they did not recheck the temperature and they dished the pureed meal for the resident. The meal was then put into the enclosed metal cart to be delivered. The meal for R12 was then pushed out of the kitchen and was in route for delivery to the resident room. Surveyor asked DM F who would have been served the puree today, and DM F said R12 and R1 were the only two who received the pureed diet that day. These 2 residents had the potential to be affected by the unsafe food temperature. Surveyor then asked DM F and DA G what temperature they would expect food to be held at prior to service. DM F said at least 130 degrees Fahrenheit, they believed. Survey asked what the temperature of the puree had been when they took temperature at the beginning of service, and DA G said it was at 128 degrees Fahrenheit. Surveyor then asked DM F what they would have expected to have been done if any food temperature was found to be below the normal food holding limit. DM F said they should have caught that and heated the puree dishes back up to an appropriate temperature prior to serving. There was no intention of reheating the puree dishes which were to be served to two residents residing in the facility. Before the food could be delivered to R12 it was taken back to the kitchen and reheated. It was noted the signage posted next to the bulletin board in the kitchen read the food should be held at least 135 degrees at the lowest. On 07/03/24 at 8:39 AM, Surveyor interviewed DM F regarding their expectations for the concerns noticed during survey. When asked about covering the food when traveling down the halls, DM F said they would expect food to be covered, and if they were to send an individual tray, they would cover all items on the tray not just the main course. DM F said they would want the food covered if being walked down the hall out of the holding cart. When asked about expectations for holding temperatures for food, DM F said they would expect the food be held at 135 degrees Fahrenheit or above, unfortunately it was missed and won't happen again.