STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525426	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillview Health Care Ctr	3501 Park Lane Dr LA Crosse, WI 54601

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and policy review, the facility failed to ensure a care plan was developed to provide effective and person-centered care and services that meets the professional standards of quality of care for 5 of 22 sampled residents (R1, R2, R9, R27, and R30). Findings include: 1. Review of R9's Face Sheet, located in the electronic medical record (EMR), revealed R9 was admitted on [DATE] with diagnoses of urine retention, schizoaffective disorder, adjustment disorder, borderline personality disorder, and obsessive-compulsive disorder. Review of R9's quarterly Minimum Data Set, located in the EMR and with an Assessment Reference Date (ARD) of 11/11/25, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated R9 was cognitively intact. The MDS also indicated R9 received non-invasive ventilator (ventilator or respirator) treatment. Review of R9's Physician Orders, located in the EMR, revealed the following order dated 01/13/26: CPAP [continuous positive airway pressure] settings 5-12 [centimeters of water pressure] H20 to be applied for sleep and/or naps AM (morning) shift PM (night) shift. Further review of this document revealed the following order dated 01/13/26: Albuterol sulfate HFA (Hydrofluoroalkane) 108 (90 base) mcg (microgram)/ACT (actuation) dose: (2 puff) inhalation every 4 hours as needed for wheezing. Review of R9's Care Plan, located in the EMR, revealed the resident care plan did not address the needs noted above in the physician orders or address the residents' respiratory needs. 2. Review of R27's Face Sheet, located in the EMR, revealed R27 was admitted on [DATE] with an admission to hospice. Review of R27's Physician Orders, located in the EMR, revealed the following order dated 10/22/24: Admit to hospice 10/22/2024 . Review of R27's quarterly MDS, located in the EMR and with an ARD of 01/02/26, revealed the resident had a BIMS score of 15 out of 15, which indicated R27 was cognitively intact. The MDS also indicated R27 was receiving hospice services. Review of R27's Care Plan, located in the EMR, revealed the resident care plan did not address the needs or use of Hospice services. 3. Review of R30's Face Sheet, located in the EMR, revealed R30 was admitted on [DATE] with admission to hospice. Review of R30's Physician Orders, located in the EMR, revealed the following order dated 01/02/26: risperidone 0.5 mg (milligram) tablet disintegrating dose (1 tablet/0.5mg) by mouth daily for dementia with behavioral disturbances Review of R30's quarterly MDS, located in the EMR and with an ARD of 01/12/26, revealed the resident had a BIMS score of 15 out of 15, which indicated R30 was cognitively intact. The MDS also indicated that R30 received antipsychotic medication. Review of R30's Care Plan, located in the EMR, revealed no plan to address psychological needs and antipsychotic medication side effects. During an interview on 02/11/26 at 9:50 AM, Registered Nurse (RN) 2 stated that all the nurses can add to the care plans. She stated that antipsychotic medications and CPAP should both have a care plan. The information on the care plans feeds into the KARDEX (care summary) to help care for the residents. During an interview on 02/10/26 at 12:18 PM, the Director of Nursing (DON) stated care plans were started by the nurse supervisors, and the nurse would take the CAA (care area summary) and create a care plan. During a follow-up interview on 02/12/26 at 10:49 AM, the DON stated care plans let staff know what was needed to care for the residents. She stated antipsychotic (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medications and breathing treatments should have a care plan. She stated she was unaware there needed to be a specific hospice care plan. 4. Review of R1's Face Sheet, located in the EMR, revealed R1 was admitted to the facility on [DATE] with a diagnosis of long-term use of anticoagulants and a prosthetic heart valve. Review of the annual MDS, located in the EMR and with an ARD of 12/03/25, revealed R1 had a BIMS score of 15 out of 15, which indicated R1 was cognitively intact. The MDS recorded R1 was administered an anticoagulant during the seven-day observation period. Review of the 01/26/26 Physician Order, located in the EMR, revealed, Coumadin [Warfarin-an anticoagulant medication] 5 mg [milligram] Dose: (1tablet/5mg) by 03/08/2026 for Anticoagulant Therapy Administration daily. Recheck INR [international Normalized Ratio-a standardized lab test that measures how long it takes for blood to clot] on 03/09/26. Review of the Comprehensive Care Plan, located in the EMR, revealed no focus/problem, goal, or approaches for the use of R1's anticoagulant medication. During an interview on 02/09/26 at 10:02 AM, R1 stated, I have been on Warfarin since 2014 for my heart condition. During an interview on 02/10/26 at 9:17 AM, the DON stated, The admission nurse will start the baseline care plan and within 48 hours it becomes more comprehensive. The DON was asked why the Warfarin was not care planned due to being a significant medication. The DON stated, We did not care plan it because it was on the MAR [medication administration record]. 5. Review of R2's Face Sheet, located in the EMR, revealed R2 was admitted to the facility on [DATE] with a diagnosis of Type 1 Diabetes and long-term insulin use. Review of the quarterly MDS, o located in the EMR and with an ARD of 11/17/25, revealed R2 had a BIMS score of 14 out of 15, which indicated R2 was cognitively intact. It was recorded R2 had received insulin during the seven-day observation period. Review of the Physician Orders located in the EMR, revealed: a. 06/27/25: Blood Glucose Check: every 4 hours. If Dexcom [a specialized glucose monitor that checks glucose levels 24 hours a day] reading is <70 or >450, obtain finger stick to confirm reading.b. 06/27/25: Insulin Aspart [short-acting insulin] three times a day for type 1 diabetes sliding scale: 150-199 give 2 units; 200-249 give 3 units; 250-299 give 4 units; 300-349 give 5 units; 350-399 give 6 units; 400-499 give 7 units; greater than or equal to 450 give 8 units.c. 07/14/25: Insulin Aspart: Give 5 units daily at supper.d. 07/21/25: Insulin Aspart: Give 13 units daily at breakfast.e. 10/12/25: Insulin Aspart: give 3 units daily at lunch. Review of the Comprehensive Care Plan did not show a focus/problem, goals, or approaches related to R2's type 1 diabetes. During an interview on 02/11/26 at 9:13 AM, RN1 stated, I am sorry, he should have a care plan for his diabetes. Review of the policy titled Care Plan - Development and Updating, dated 12/31/25, revealed, Care plans include instructions needed to provide effective, person-centered services, which should include the individual's strengths, needs, goals, meds, social services, . Care plans will be updated as changes occur and as often as needed. This is to include things like changes to level of function, treatments, and skin care.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview, record review, and policy review, the facility failed to ensure the urinary catheter drainage bag was covered for privacy and dignity for 1 of 2 Residents (R9) reviewed for urinary catheters out of a total sample of 22. Findings include:A review of the policy titled Resident Rights, dated 06/30/25, revealed Respect, Dignity, and Self-Determination: you have the right to be treated with respect and dignity.Review of R9's Face Sheet, located in the electronic medical record (EMR), revealed R9 was admitted on [DATE] with diagnoses of urine retention.Review of R9's quarterly Minimum Data Set (MDS), located in the EMR and with an Assessment Reference Date (ARD) of 11/11/25, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated R9 was cognitively intact. The MDS revealed R9 used an indwelling catheter.Review of R9's Care Plan, located in the EMR and dated 01/13/26, revealed R9 had a catheter for urinary retention. A goal for this was to have R9's dignity remain intact.Review of R9's Physician Orders, located in the EMR and dated 01/27/26, revealed the following order dated 01/27/26: Foley catheter 18 fr [French foley]/5 ml [milliliter] silicone only. An observation on 02/09/26 at 10:43 AM revealed R9 wearing a urinary catheter bag with no privacy cover. The bag was attached to her left calf. R9 was wearing a skirt that covered just past her knees, and urine was noted in the bag. R9 was observed in her room; however, the bag could be seen from the hallway.During an interview on 02/09/26 at 12:14 PM, R9 stated the bag and exposed urine bothered her. She stated she wished there was something to cover it with.During an observation on 02/10/26 at 9:25 AM, R9 was observed propelling in her wheelchair in the hallway. R9's urinary catheter bag was observed attached with a strap to her left calf. The catheter bag was exposed, and the urine could be seen in the bag.During an interview on 02/10/26 at 9:26 AM, Certified Nursing Assistant (CNA) 6 confirmed R9 did not have a privacy cover on her catheter bag.During an interview on 02/11/26 at 9:50 AM, Registered Nurse (RN) 2 stated all catheter bags should have a privacy cover on the bag. She then confirmed that R9 did not have a privacy cover on her bag.During an interview on 02/12/26 at 10:49 AM, the Director of Nursing stated R9 should have a privacy cover on her catheter bag to ensure her dignity was respected.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and review of facility policy, the facility failed to provide a notice of hospital transfer and appeal rights for one resident (R28) in a total sample of 22. Findings include: Review of the 07/31/25 facility policy titled, Discharge/Transfer Documents revealed, Transfer Form/Patient Care Plan-Any resident being transferred to the hospital shall have a Resident Transfer Form filled out by Nursing Service and the Hospital Transfer Checklist completed. A copy of the transfer from (original) shall be sent with the resident and a copy will be filed in the medical record. Review of the Face Sheet located in the Face Sheet tab of the electronic medical record (EMR) revealed R28 was admitted to the facility 10/07/25 after sustaining a fracture arm/wrist from a fall at home. Review of the quarterly Minimum Data Set (MDS), located in the MDS tab of the EMR and with an assessment reference date (ARD) of 12/31/25 revealed R28 had a Brief Interview of Mental Status (BIMS) score of 12 out of 15, which indicated R28 was moderately impaired in cognition. Review of the Nursing Notes of the EMR revealed, On 10/17/25 R28 complained of nausea with yellowish brown liquid emesis x 1. Continues to [NAME] with fluid intake. Resident was positioned on her left side with HOB [head of bed] elevated at 45 degrees. Nursing interventions were continued and at 10:54 AM, [R28] requested to go back to hospital due to continued emesis and abdominal pain. Resident was admitted for ileus [a cessation of normal intestinal movement]. R28 returned to the facility on [DATE]. During an interview on 02/11/26 at 11:57 AM, the Director of Nursing and Administrator was asked if the resident and/or her representative was notified in writing of the hospital transfer and appeal rights when she was admitted to the hospital on [DATE]. The Administrator stated, I don't think we have done this. During an interview on 02/12/26 at 10:30 AM, the Support Systems Manager (SSM) stated, We used to have a transfer form for residents/representatives which included their appeal rights. The SSM confirmed that the transfer form was not provided to R28 and/or her representative at the time of the transfer to the hospital.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to obtain a signed declination which contained education on the risks/benefits of the influenza vaccine for 2 of 5 Residents (R18 and R30) reviewed for vaccines. Findings include: Review of the facility policy titled, Acute Respiratory Illness Protocol, dated 11/30/25 revealed, . Consent will be obtained from the resident or his/her responsible person prior to administration of vaccine. A declination form will be completed by resident or his/her responsible person if they choose to decline the vaccine . 1. Review of the Face Sheet, located in the electronic medical record (EMR), revealed R18 was admitted to the facility on [DATE] with a diagnosis of cancer with metastasis to the bone. Review of the annual Minimum Data Set (MDS), located in the EMR and with an assessment reference date (ARD) of 01/20/26, revealed R18 had a Brief Interview of Mental Status (BIMS) score of 15 out of 15, which indicated R18 was cognitively intact. It was recorded R18 was offered and declined the influenza vaccine. Review of the EMR and the Hard Chart at the nursing station revealed no documented evidence of a signed declination for the influenza vaccine, including that education on the risks and benefits of the vaccine was provided to R18. 2. Review of the Face Sheet, located in the EMR, revealed R30 was admitted to the facility 10/25/24 with diagnoses that included a personal history of mental and behavioral illnesses. Review of the quarterly MDS, located in the EMR and with an ARD of 01/12/26, revealed R30 had a BIMS score of 15 out of 15, which indicated R30 was cognitively intact. It was recorded R30 was offered and declined the influenza vaccine. Review of the EMR and the Hard Chart at the nursing station revealed no documented evidence of a signed declination for the influenza vaccine, including that education on the risks and benefits of the vaccine was provided to R30. During an interview on 02/12/26 at 10:50 AM, the Director of Nursing (DON) confirmed that she was not aware that a declination of a vaccine needed to be in the medical record with the documentation to show that the risks/benefits were explained to the resident.