STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525453	A. Building B. Wing	06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clearview	198 County Df Juneau, WI 53039

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50228 Based on interview and record review, the facility did not immediately notify and consult with a resident's physician when there was a significant change in condition. This occurred for 1 of 17 residents (R46) reviewed for change in condition. R46 had a change in condition on 5/5, 5/26, and 6/10/24 that was not reported to R46's provider timely. This is evidenced by: The facility policy, entitled Physician Notification/Change in Condition dated 1/22/2024, states, in part: Policy: .A change in condition is when there is: .2. A significant change in the resident's physical, mental or psychological status (that is a deterioration in health, mental or psychological status in either life-threatening conditions or clinical complications. 3. A need to alter treatment significantly (that is. a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment.Please refer to the attached physician notification parameters tool for more information about falls and other conditions requiring physician notification. Alteration in mental status: Immediate notification-sudden change in mental status: lethargy, loss of consciousness, syncope, vertigo. According to the American Medical Directors Association Acute Change of Condition in Long-Term Care Setting standard of practice. A facility should notify the physician for bleeding the next office day when the bleeding is controlled with no further episodes .Alteration in mental status: sudden notify immediately. R46 was admitted to the facility on [DATE], and has diagnoses that include Non-ST elevation myocardial infarction (a type of heart attack), unspecified diastolic heart failure (heart condition which reduces the amount of blood [NAME] out to the body), venous insufficiency (a condition which decreases the leg veins ability to send blood back to the heart), chronic atrial fibrillation (an irregular and often rapid heart rhythm), and personal history of renal calculi (kidney stones / hard deposits of minerals and salts inside the kidneys). (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R46's Quarterly Minimum Data Set (MDS) assessment dated [DATE] shows R46 has a Brief Interview of Mental Status (BIMS) score of 6, indicating severe cognitive impairment. R46's progress notes include: 5/5/24 4:57AM- Writer called to room as resident was noted to have frank blood in his pull-up (incontinent brief). Upon further assessment, resident noted to have hematuria (blood in urine) with small amount of blood from penis. No open areas noted. Resident has had this before. Denies any pain/discomfort. Resident is afebrile. Will continue to monitor. No documentation indicating R46's provider was updated. 5/26/2024 4:36 PM- Writer called to resident's room. Resident was sitting on the toilet and CNA was attempting to arouse resident, which was difficult. Vitals were taken at this time and WNL (within normal limits). Staff then transferred resident into bed via golvo lift (mechanical transfer device). RN notified about event and came to unit No documentation indicating R46's provider was updated. 5/26/24 4:51PM- called to unit for resident's unresponsive episode. Resident is seen lying in bed, alert. He does not recall passing out. Resident most likely with vasovagal response (a sudden drop-in heart rate and blood pressure leading to fainting) as he is alert at time of assessment. Pulse is 40, not unusual for this resident .updated provided to dtr (daughter) via phone call. No documentation indicating R46's provider was updated. 6/10/24 9:48PM- writer summoned to resident's bathroom by staff who report bright red blood in resident's urine during his shower. Writer observed and confirmed bright red blood present. Resident denies any s/sx's (signs / symptoms) consistent with UTI (urinary tract infection). Resident is afebrile (free of fever). RN notified. No documentation indicating R46's provider was updated. On 6/13/23 at 9:54 AM, Surveyor interviewed RN E (Registered Nurse). Surveyor asked if a resident is experiencing hematuria (blood in urine) what would be the next steps. RN E stated it would depend on the resident's diagnosis and medications. If there is a large amount of blood or pain or if the bleeding is new the physician should be notified right away or within 24 hours. Surveyor asked if a resident is sitting on the toilet and becomes difficult to arouse, what would be the next steps. RN E stated, call the nurse, sternal rub, if arouses assist to bed or chair, if new condition update physician right away. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/13/24 at 10:20 AM, Surveyor interviewed RN H. Surveyor asked if a resident is experiencing hematuria what would be the next steps. RN H stated ensure it is urinary related, not an open area or other symptom, check diagnoses, if new issue update physician. Surveyor asked what is the timing of that update to the physician. RN H stated fairly quickly, if all else is stable (no other signs and symptoms) within 2 hours. Surveyor asked if a resident is difficult to arouse what are the next steps. RN H stated check vital signs, check that all else is normal, check to see if this is something that occurs for this resident, ensure safety, ensure that the resident comes around. If new for the resident, update the physician right away and ask about any additional orders. Surveyor read progress note from 5/25/24 and asked if physician should have been notified. RN H stated this is not a resident that she knows has had incidents in the past and if this is not normal for him the physician should have been notified. He does get diuretics (water pills) twice daily, there are things that we could do right away. RN H stated that she would like to review the resident's chart. At 10:43AM, RN H stated after looking at the chart, I would've updated the physician right away when it happened. He was changed to palliative care on 5/6/24, but there are notes about hematuria, low pulse, poor intake, doc (Physician) should have been updated at that time. There was a progressive change, and he may have needed a change in his orders at that time. On 6/13/24 at 2:40 PM, Surveyor interviewed RN I. Surveyor asked if a resident is experiencing hematuria what are the next steps. RN I stated it depends if it is chronic or acute, if new will contact physician. If chronic, then no need to call unless there is a large amount of blood. Surveyor asked is hematuria a concern for R46. RN I stated I don't recall. If it is new for him there should be a call to the doctor. Surveyor asked if a resident is difficult to arouse what are the next steps. RN I stated it depends on the situation, but an assessment should be done. Surveyor asked if a resident has a vaso-vagal incident should the physician be notified. RN I stated it depends; I wouldn't leave my shift knowing something was off with him. Surveyor asked when the physician might need to be updated in relation to a pulse. RN I stated immediate notification per the facility parameters. On 6/13/24 at 3:15 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked if a resident is having hematuria would you expect staff to notify the physician. DON B stated yes, especially if it is something new. Surveyor asked if a resident is difficult to arouse and staff assess a resident with a vaso-vagal incident would staff be expected to update the physician. DON B stated if it is new, yes.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38882 Based on interview and record review the facility did not ensure prompt resolution of all grievances for 2 of 14 residents (R47 and R32) reviewed for grievances out of a total sample of 17 residents. R47 voiced a grievance/concern to staff and did not receive any follow up on her voiced grievance/concern. R32 voiced a grievance/concern to staff and did not receive any feedback or a resolution to her concern/grievance. Evidenced by: Facility policy, entitled Grievance Policy and Procedure, effective date of 12/11/23, includes, in part: . staff are to ensure the prompt resolution of all grievances regarding the resident's rights. Any person is able to freely voice having a concern or problem with any matter concerning their rights including those with respect to care and treatment . the behavior of staff and other residents, and other concerns regarding their long-term care facility stay. (Facility Name) promotes an environment with the objective that all residents feel comfortable . The party shall provide verbal or in written statement describing his or her grievance/concern to the household Social Services staff, Registered Nurse, or any other staff member with whom he/she feels comfortable . Any household staff member made aware of a grievance/concern will notify the Director of Social Services/Grievance Officer . An investigation will be conducted concerning the grievance and its cause. Within 5 business days, if possible, a resolution to the grievance shall be determined following a review of the investigation results. The party who filed the grievance will then receive a summary of the grievance, findings, conclusion, and any action taken. If the party is still not satisfied with the disposition of the grievance, the party may bring the grievance to the attention of the Administrator and Administrative Team . Example 1 R47 admitted to the facility on [DATE]. Her most recent MDS (Minimum Data Set) with ARD (Assessment Reference Date) of 3/14/24 indicates R47 is cognitively intact with a BIMS (Brief Interview for Mental Status) score of 15 out of 15. On 6/11/24 at 10:59 AM R47 voiced a concern related to the quality of food being served in the facility. R47 indicated she told LPN D (Licensed Practical Nursing) about her concern and she saved some meat to show management. R47 indicated the facility did not follow up with her concern. R47 indicated she feels like it is no use bringing concerns forward if there will not be any follow up. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/11/24 at 4:06 PM during an interview LPN D (Licensed Practicing Nurse) indicated R47 reported to her a concern regarding the chicken in her pot pie on 6/1/24. LPN D indicated she did not fill out a grievance, did not start an investigation, and did not meet with R47 related to a resolution to her grievance. LPN D indicated she was not sure if this happened once or if R47 had concerns related to the quality of other foods. LPN D indicated any concern related to residents' stay or care is considered a grievance and she should have followed the facility grievance process. On 6/13/24 at 10:55 AM during an interview SW C (Social Worker) indicated residents can voice concerns to any staff member or can fill out a grievance form. SW C indicated when staff receive concerns, they are to fill out a grievance form and then the Grievance Official will oversee the grievance process and alert all who need to be involved in an investigation. SW C indicated there was not a grievance form with this concern on it and if there was an investigation it would have been completed and a resolution would have been discussed with R47. SW C indicated the facility can't track and trend if grievances are not recorded using the grievance process. On 6/13/24 at 11:17 AM DON B (Director of Nursing) indicated staff need to fill out grievance forms for all resident concerns so the facility can investigate, track, trend, and work out a resolution to the residents' concerns. DON B indicated there are only 3 grievances recorded since January 2024. Example 2 R32 admitted to the facility on [DATE]. Her most recent MDS with ARD of 3/21/24 indicated R32 is cognitively intact with a BIMS score of 15 out of 15. On 6/11/24 at 10:26 AM R32 voiced a concern about CNA F (Certified Nursing Assistant)being grumpy, unfriendly, rough, disrespectful, nasty and was taking it out on R32. R32 indicated CNA F would not assist her with rearranging things in her room because she did not have time. R32 indicated she verbally reported this grievance to RN E (Registered Nurse) and has not heard anything back about the follow up from her concern. R32 indicated this interaction was not nice and made R32 feel like a bother. R32 indicated she relies on staff to meet her daily needs and stated, I'm in a wheelchair so I can't bend over and do some things. On 6/12/24 at 10:44 AM RN E indicated R32 voiced a concern to her regarding CNA F dressing inappropriately and being in her room complaining about being the only staff on the unit, complaining about being underpaid, and complaining about being overworked. RN E indicated CNA F should not be talking like this in a resident room as it can cause a resident to have mental anguish. RN E indicated she was unsure if other residents had concerns related to CNA F. RN E indicated she did not follow the facility's grievance process/policy or the facility's abuse process/policy. RN E indicated she did not think this was an allegation of abuse and should have filled out a grievance form so the facility management team could have investigated this further. Surveyor reviewed CNA F's personnel file and had no concerns with education or with disciplinary actions. On 6/13/24 at 11:17 AM DON B indicated staff need to fill out grievance forms for all resident concerns so the facility can investigate, track, trend, and work out a resolution to the residents' concerns. DON B indicated there are only 3 grievances recorded since January 2024.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49434 Based on observation, interview, and record review, the facility failed to ensure that lab values were monitored according to professional standards of practice for one resident (R8) out of 17 reviewed for professional standards of care. Specifically, the facility failed to properly identify and notify staff of one resident's lab value that differs from the accepted therapeutic range, which has the potential to cause R8 to experience adverse effects from not properly holding or administering the medication. R8 was recommended an INR (international normalized ratio, assesses how fast blood clots) therapeutic range from 1.5 to 2, which was not made readily available to nursing staff to review prior to holding or administering medication. Findings include: The National Library of Medicine's article titled International Normalized Ratio (INR) (2023), indicates: For normal patients who are not on anticoagulation (blood thinning medication), the INR is usually 1.0 regardless of the ISI (international sensitivity index) or the particular performing laboratory. For patients who are on anticoagulant therapy, the therapeutic INR ranges between 2.0 to 3.0. INR levels above 4.9 are considered critical values and increase the risk of bleeding . Complications: INR level below the target range is associated with increased risk of thrombosis (blood clot). Research showed that more than three-fold risk of recurrent venous thromboembolism (blood clot in veins) is associated with the subtherapeutic INR level. On the other hand, INR above the therapeutic range is associated with increased risk of bleeding among which the most concerning condition is an intracranial hemorrhage (brain bleed). Patients can also present with gastrointestinal bleeding (stomach or intestinal bleeding), hematuria (blood in urine) or bleeding from any other site. Review of the facility policy titled Warfarin (Coumadin)(anticoagulant) Therapy last reviewed on 11/23/23 states in part, Policy: All residents receiving Warfarin therapy will receive monitoring per resident observation and INR lab draws as ordered by the physician. Additionally, the policy states, Procedure: 5. Upon received of the results, the nurse will notify the physician/medical provider of INR results less than 2.0 or greater than 3.0 (unless other guidelines have been established by the physician/medical provider) .7. The nurse will notify the physician/medical provider of symptoms of active bleeding. Review of the facility policy titled Physician Orders, Obtaining and Processing last reviewed on 3/18/2024 states in part, Care Plan: 3. Use care to add information/medications/interventions to care plan in appropriate area/problem. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Diagnostic Services last reviewed on 1/20/2023 states in part, Guideline: AMDA- Acute Change of Condition in[sic] the Long-Term Care Setting Clinical Practice Guideline. The policy also states, Procedure: 3. Lab results in the extreme low (XL), panic high (PH) range, or that are positive (See Appendix A-attached) will be reported to the physician promptly, on the same day they are drawn/results obtained. Other results to be reported promptly are . INR/PT (prothrombin time, assesses how fast blood clots) 3 IUs (international units, unit of measurement for INR test) or above (get order to hold warfarin) . 4. INR/PT INR below 3 IUs . Of note: Appendix A lists INR critical high above 6 and no critical low is listed. R8 was admitted to the facility on [DATE] with diagnosis that include in part . Hemiplegia (one-sided paralysis or weakness) and hemiparesis (one-sided muscle weakness) following cerebral infarction (stroke) affecting left non-dominant side, unspecified fracture of T9-T10 (fracture of vertebra in the spine), paroxysmal atrial fibrillation (uncontrolled irregular heart rhythm), hypertension (high blood pressure), and long-term use of anticoagulants. Review of R8's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/14/2024 indicates R8 has a Brief Interview for Mental Status (BIMS) score of 15 of 15, which indicates R8 is cognitively intact. Primary medical condition is listed as stroke with additional diagnosis of hypertension. The High-Risk Drug Classes indicates R8 is receiving an anticoagulant. R8's care plan states, in part, Problem: Alteration in Cardio-respiratory Perfusion/Neurological Status r/t Disease Process- A-fib (atrial fibrillation), HTN (hypertension), Hx (history) of CVA (cerebrovascular accident-stroke) with L (left) hemiparesis/plegia AEB: SOB (shortness of breath) with exertion, edema (swelling), hx long term use anticoagulant . Approach: Monitor for any s/s (signs/symptoms) of active bleeding (blood in stools, epistaxis (bloody nose), bruising). Of note: There is no indication on the care plan specifying R8's INR range. Physician's order dated 3/11/2021, states in part, May HOLD any meds if condition warrants. Physician order dated 3/28/2024, states in part, LABS: INR weekly . warfarin tablet; 1 mg (milligram); amt: 1 tab; oral Special Instructions: give 1 tab PO (by mouth) daily at 1900 (7:00 PM) for anticoagulant. Of note: Physician orders do not indicate R8's INR range. In review of R8's EMAR (electronic medication administration record), the facility administered warfarin as ordered from 5/12/2024 through 6/9/2024. The medication was held (not administered) on 6/10/2024 and 6/11/2024 for an INR of 2.6. In review of R8's progress note dated 6/6/24 at 9:25 AM, [Physician] reviewed INR again from yesterday as [APNP] did review yesterday, with INR being 2.6, no hematuria noted at this time, with no new orders to be given. Progress note dated 6/8/24 at 9:29 PM states, Hematuria noted in urine this evening. Resident offers no c/o (complaint). RN updated, will continue to monitor. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Progress notes dated 6/9/24 at 6:33 AM and 10:11 PM state, Moderate hematuria, no c/o pain or discomfort and Resident continues w/ frank blood (bright red blood) in urine. No c/o offered. Progress note dated 6/10/24 at 9:10AM states, MD SEE: [Physician] saw resident for routine see, reviewed physician orders, VS (vital signs), weights, and overall status, note to be dictated when she returns to her office. [Physician] updated on hematuria over the weekend, noting last INR was 2.6, with new order to hold coumadin tonight on 6/10 and to recheck INR on Wednesday. Physician progress note dated 6/10/2024 states R8 has an INR goal between 1.5 and 2. Of note: This note is the only indication, in the paper or electronic record, of R8's recommended INR range. Progress note dated 6/11/24 at 12:45 PM states, [APNP] in house and updated that hematuria continues w/ resident, noting that coumadin (warfarin) was held last night per [Physician] order. New order given today to hold coumadin tonight and wait for INR tomorrow. In review of the R8's paper chart on 6/12/2024 at 2:22 PM, Surveyor located a page titled Temporary Changes/New Problems Log, this sheet was blank upon review. A Physician Order Sheet includes the following orders: 6/10/24-hold coumadin x1 tonight, 6/11/24-hold warfarin today, 6/12/24-hold warfarin tonight 6/12/24, coagulation tomorrow 6/13/24. A sheet titled Anticoagulant/INR Tracking Form was also located with R8's name at the top and three entries, the last being on 8/9/2023. This sheet also contains a note stating, per [Physician]- no spreadsheet needed for INR. Of note: Nothing in the R8's paper chart indicated the resident's INR range. On 6/12/24 at 3:53 PM, Surveyor interviewed RN I (Registered Nurse). Surveyor asked RN I what the process is for notifying a physician after receiving lab results. RN I stated that if the lab value is outside parameters, they scan the results and email them to the nurse practitioner and physician. If RN I doesn't hear anything back within an hour, RN I will call the on-call physician. Surveyor asked RN I what the normal INR range is according to standards of practice. RN I was unsure but reported that R8 is supposed to be on the lower end of the therapeutic range. Surveyor asked RN I where the prescribed therapeutic range for R8 was located. RN I stated that it should be listed in the chart, and that residents will be at different therapeutic ranges depending on why they are taking warfarin. RN I stated that R8 is on brittle warfarin because when she has an INR of two, R8 starts having blood in her urine. Surveyor asked RN I to show them where the ordered therapeutic range can be found in the chart. RN I was unable to locate this information. On 6/12/24 at 3:58 PM, Surveyor interviewed RN J. Surveyor asked RN J what her expectation would be for receiving a lab result outside of expected parameters. RN J states that it depends on the patient. Surveyor asked RN J specifically regarding R8's lab parameters. RN J states that she does better on a low INR and that the physician is aware. RN J also states that R8 is better off when she is below 2 because she ends up with hematuria (blood in urine). RN J also reported that staff have held warfarin for several days due to an INR result of 2.6 and 2.3. Surveyor asked RN J at what level hematuria is likely to occur for R8. RN J states that R8 usually has hematuria with an INR over 2. Surveyor asked RN J how staff track R8's INR range. RN J states that staff keep an INR tracking sheet in the paper chart, but that they are not using that sheet per physician order because the resident doesn't need to be in the normal therapeutic range to avoid hematuria. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/12/24 at 4:33 PM, Surveyor interviewed RN I. Surveyor asked RN I if she would expect R8's therapeutic INR range to be recorded in the chart. RN I said yes. Surveyor asked RN I what the process is for holding medications. RN I said this isn't commonly done on their shift, however when the staff RN receives the lab result, if it is out of range, the nurse holds the medication on the EMAR (electronic medication administration record) and notifies the physician. Surveyor asked RN I how they know what to report to the physician if no INR range can be found in R8's chart. RN I reported that they report every INR result or look at the last result to compare. On 6/13/24 at 10:07 AM, Surveyor interviewed RN K. Surveyor asked RN K to show Surveyor where the ordered therapeutic INR range could be found for R8. RN K was unable to locate this information in the paper chart. RN K then looked through the electronic medical record. The only indication of an ordered therapeutic INR range for R8 was located in a physician progress note from 6/10/24, after Surveyors were already in the building and questioning R8's INR range. Previous physician progress note also read from April of 2024 and it did not indicate a therapeutic INR range for R8. RN K stated that there is a policy with a lot of different lab values that specifies when to update the physician. Surveyor referenced this policy previously, and only indicates reporting around the normal INR therapeutic range. On 6/13/24 at 10:55 AM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B where she would expect to find a resident's ordered INR reference range. DON B states that she would expect to find this information in the physician's orders. Surveyor asked DON B if physician recommendations are considered orders at this facility. DON B indicates that physician recommendations are considered orders. Surveyor asked DON B where she would expect to find a therapeutic INR value if she was unfamiliar with R8 or any other resident. DON B indicated that she would expect to find it on the Anticoagulant/INR Tracking Form and in the care plan. The facility did not ensure that physician's orders for R8's therapeutic lab values were easily accessible and documented for all staff to review as needed in accordance with professional standards of practice.

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F 0689 Level of Harm - 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** 48623 Based on observation, interview, and record review, the facility did not ensure a resident's environment remained free of accident hazards and each resident received adequate supervision and assistive devices to prevent accidents for 1 of 1 resident (R) reviewed for accidents (R14). Facility staff did not ensure R14's reclining chair remote was out of her reach per R14's care plan. R14 lifted the chair without staff present and fell resulting in a fracture. Evidenced by: The facility's Policy and Procedure entitled Fall Prevention and Management with a last reviewed date of 4/11/23 documents, in part: .Each resident be reviewed on admission, quarterly and with major change of condition for the potential fall risks, and preventative interventions taken when necessary. The purpose of the falls prevention and management program is to identify residents at risk for falls, initiate preventative approaches, and monitor and evaluate resident outcome. Should a resident fall, the licensed nurse will complete the documentation regarding the event in the electronic health record. The information will be reviewed to see if there were any contributing factors to the fall and interventions will be added to the plan of care as needed. (Which could include resident, family and/or staff education). R14 was admitted to the facility on [DATE] and has diagnoses that include in part: Hemiplegia and Hemiparesis following cerebral infraction affecting right dominant side (Disrupted blood flow to the brain causing muscle weakness and partial paralysis to the right side,) Unspecified fracture of shaft of right tibia, unspecified fracture of lower end of right femur, unspecified fracture of shaft of left tibia, closed fracture with routine healing, unspecified fracture of shaft of left fibula, Paroxysmal atrial fibrillation, Essential hypertension, Aphasia, Dysphagia, Osteopenia (lower than normal bone mass), and history of falls with fractures. R14's Significant Change Minimum Data Set (MDS) with a target date of 2/19/24 indicates R14 has a BIMS (Brief Interview for Mental Status) of 15 out of 15. R14 is dependent for toileting, personal hygiene, and upper and lower body cares. R14 requires extensive assistance in bed and transfers with the assistance of three staff members and the Golvo (full body lift). R14's Fall Risk tool, dated 1/13/24 at 2:46 PM, has a score of 16 which indicates R14 is at risk for falls. (continued on next page)

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Clearview	198 County Df Juneau, WI 53039

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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 0689 Level of Harm - Actual harm Residents Affected - Few	R14's Fall Event Report dated 1/20/24 at 7:45 AM, and a completion date of 1/22/24 at 04:06 (4:06 AM) AM states in part: .Description: noted on floor. Fall details: Date/time of occurrence: 01/20/2024 07:45 (7:45 AM). Type of fall, .noted on floor. Describe the event: Resident had been sitting in recliner. Resident then kept pushing button on recliner which then kept tilting the char [sic] forward causing resident to slide out of recliner and onto the floor.Where did the fall occur? Resident room . R14 yelling out intermittently. Range of motion assessment completed, range of motion per usual for resident. How was the environment when the fall occurred? Quiet .activity of resident at the time of the fall .sitting in chair .equipment being used: .recliner. Interventions already in place: keep call light in reach at all times. Monitor for mood, behavior or cognitive changes that may affect safety awareness patterns. Monitor for side effects of psych meds: low BP (blood pressure), gait disturbance, EPS (extrapyramidal side effects), vertigo lethargy etc. interventions to prevent reoccurrence. Staff to not place recliner remote by resident unless staff are there to observe how resident is using the remote . 24-hour follow-up documentation: AM follow-up: continues with complaints of lower back pain (chronic) PRN tramadol given. No injury noted. PM follow-up: Resident c/o (complains of) mild pain earlier in day, no further c/o throughout the evening. Neuro (neurological) checks WNL (within normal limits) with no c/o headache, nausea, or dizziness. No injury noted. NOC (night shift) follow-up: Neuro checks WNL with complaints of dizziness, headache, or nausea. Resident denies any pain or discomfort. Resting comfortably. No injury noted . (Of note: the facility falls investigation indicates that the new fall intervention put in place to prevent reoccurrence is, staff to not place recliner remote by resident unless staff are there to observe how the resident is using the remote. This intervention was added to the care plan on 1/20/24.) R14's care plan dated 1/20/24, states in part: Problem: Falls . interventions: staff to not place recliner remote by resident unless staff are there to observe how resident is using the remote. Place bed at height determined to be safe for resident's functional abilities with brakes locked. Provide resident an environment free of clutter and the floor is free of glare, liquids, and foreign objects . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R14's Fall Event report with even date of 1/22/24 at 2:14 PM and completed date of 1/27/24 at 6:47 AM, states in part: Description slid out of recliner. Fall details. Date/time of occurrence: 01/22/2024 13:15 (1:15 PM). Type of fall .slid out of chair .Describe the event: Resident resting in recliner after lunch. Staff alerted by resident's crying, noting resident on the floor with her electric recliner in the up position, causing resident to slide out of chair. Resident (R14) noted to be laying on her right side on the floor between the recliner and the bathroom wall. Resident states that she did hit her head. Skin check completed with no injury noted. Resident (R14) assisted with the Golvo lift and 3 assist back into bed. Neuro checks initiated. Where did the fall occur? Resident room . How was the environment when the fall occurred? Quiet . Activity of resident at the time of the fall .sitting in recliner . interventions already in place: staff not to place recliner remote by resident unless staff are there to observe how resident is using the remote. Call light within reach. Keep personal items within reach of resident. Cause: Resident incorrectly using recliner remote. Interventions to prevent reoccurrence. Manual recliner .24-hour follow-up documentation: AM follow-up: Resident continues with immobilizer placed by ER. Unable to remove immobilizer d/t (due to) cotton wrapping around it. CMS (circulation motion sensation) WNL . Resident without pain at this time. Golvo lift used for transfers - resident (R14) non wt. (weight) bearing. Will continue to monitor . PM follow-up: Resident c/o increased pain to her left ankle, I sprained it. Slight bruising to the inner ankle, no increased swelling. X-ray ordered. X-ray results show a left tibia and left fibula fracture. The resident was sent to the ER. NOC Follow-up: resident (R14) back here at 2245 (10:45 PM). (R14) is wearing a cast to left leg and leg is wrapped. R14 able to wiggle toes, no redness to toes. (R14) is NWB (non-weight bearing) and uses the Golvo lift . Of note, there is no indication on the Fall event form to indicate R14's range of motion was assessed. R14's care plan was not followed as evidence by R14 having access to the recliner remote without staff present and having a second fall out of the recliner. On 1/22/24 at 7:35 PM, R14's progress note states in part: x-ray results received showing an acute fracture involving left distal tibia and distal fibula with no/mild to minimal displacement. MD Q (Medical Doctor) updated with orders to send to ER for eval . On 6/13/24 at 5:57 PM, Surveyor interviewed LPN P (Licensed Practical Nurse). Surveyor asked LPN P if R14 had an intervention to not have access to chair remote unless staff were present, should she have had the remote to the chair? LPN P stated, I am assuming not. On 6/13/24 at 2:49 PM, Surveyor interviewed RN E (Registered Nurse). Surveyor asked RN E what interventions were in place for R14 after the first fall on, 1/20/24. RN E stated we added to the care plan not to place the recliner remote by resident, unless staff are there to observe how resident is using the remote. Surveyor asked RN E if it was communicated to everyone? Yes, the hall CNA sheets were updated, and the care plan would have been updated. RN E stated the first intervention to not place the recliner remote near the resident did not work. The new intervention: get a manual chair, did work. R14 is now in a Broda chair. Surveyor asked RN E if there was a lift chair assessment done before R14 used the lift chair. RN E stated that therapy will do an assessment with lift chairs if they work with the resident. Typically, we don't do lift chair assessments. R14's Fall Risk tool dated 1/23/24 at 3:26 PM, has a score of 14 which indicates R14 is at risk for falls. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 6/10/24 at 9:47 AM, Surveyor interviewed resident R14 while the resident was sitting in a Broda chair in front of the TV in the resident's room. The bedside table was at the side of the Broda chair with several personal items on the table. Surveyor asked R14 when you push the call light do staff come and assist you? R14 said yes, they come quickly. On 6/13/22 at 5:50 PM, Surveyor interviewed CNA N and asked, how do you know what fall interventions to use? CNA N stated that we look at the resident care cards that are printed and updated. On 6/13/24 at 5:58 PM, Surveyor interviewed CNA O and asked, how do you know what fall interventions to use? CNA O stated that we have training on the computers, and the CNA Kardex. How are new interventions communicated to you? The nurse tells us when care plans are updated. On 6/13/24 at 5:18 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B what would you expect the RN assessment to look like after a fall? DON B stated I would expect the RN to assess pain, the extremities for range of motion, have the resident move their limbs. I would expect them to ask the resident what they were doing at the time of the fall. I also expect them to take the resident's vital signs. Surveyor asked DON B who is responsible for assessing the resident at the time of a fall. DON B stated that the RN on the unit assesses the resident and completes the Fall Incident Report. Surveyor asked DON B once the team has determined an intervention, how is the new intervention communicated to the rest of the team? DON B stated that we have stand-up meetings 4 days a week, as RN teams. We disseminate information through the different license levels by providing updates from shift to shift. DON B stated that household meeting minutes are also posted on households for staff to read and review. Surveyor stated that resident R14 had a new intervention put in place recently. The intervention was that staff to not place recliner remote by resident unless staff are there to observe how the resident is using the remote. On 1/22/24, R14 had a second fall while sitting in the recliner and using the remote unsupervised. On 6/20/24 at 3:05 PM, Surveyor observed a stationary chair in R14's room, no electric recliner was observed in room. R14 was at risk for falls. R14 had a fall from the lift chair, the facility put an intervention in place to only allow R14 access to the remote with staff supervision. R14 had access to the remote without staff present, lifted the recliner chair, and fell resulting in a fracture.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 41788 Based on interview and record review, the facility has not established an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. This has the potential to affect all 52 residents. The staff line lists contain signs/symptoms (s/sx) such as something I ate, sick, ill, cold sx. They are not specific. The staff line lists were missing some Date last Symptom occurred dates. The facility's COVID summary not complete or accurate. This is evidenced by: The facility policy entitled Nursing Services/Infection Control: Infections: Reporting, Interventions, and Surveillance, dated 2/10/24, states, in part: . Policy: An infection control report will be initiated for any resident with symptoms of an infection, in order to provide a systemic approach for monitoring, controlling the spread of and reducing infections. An infection may be identified by observation of clinical signs/symptoms, physician's diagnosis, and diagnostic tests . Staff calling in ill with infectious signs/symptoms will be given guidelines of when they can safely return to work. Staff may be encouraged to consult with their own physician prior to returning to work. Staff line lists will be maintained by the ADON (Assistant Director of Nursing) . Procedure: For Staff . 2. Staff calling in with gastrointestinal signs/symptoms (vomiting, diarrhea-may also have headache, fever/chills, and abdominal cramps) are required to stay home until they are symptom free for at least 48 hours. Symptomatic staff with Influenza like illness signs/symptoms (fever, chills, cough, sore throat, runny nose) are required to stay home at least 24 hours after they no longer have a fever (without fever reducing medicines) . 3. Staff should review all signs and symptoms with infection preventionist to determine return to work date . 5. The Infection Control Nurse/ADON will maintain staff line lists which include staff names, household/department, dates when calling in, signs/symptoms if determined to be infectious, dates signs/symptoms ended, and date staff returned to work. The facility policy entitled Gastroenteritis-Like Illness, dated 2/21/24, states, in part: . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	All facility staff should be monitoring for and reporting gastrointestinal illness among residents and staff year-round . Employees will report symptoms of gastrointestinal-like illness when calling in or when on duty so as to limit the spread . D. Management of Ill Staff . 5. A log should be maintained to record ill staff symptoms, date when they became ill, date they became well, and when they returned to work by the Infection Control Nurse or designee . Example 1 The May 2024 staff line list contains 9 call ins. 3 of 9 staff did not have specific symptoms on the line lists. Symptoms include: something I ate and sick. These symptoms are not specific to allow the infection preventionist or designee to track, trend, and surveil for illnesses and outbreaks. The Date of Last Symptom dates were left blank on the staff line list for 1 resident in May. Note: Without date of last symptom the return-to-work dates cannot be determined. The March 2024 staff line list contains 16 staff call ins. 7 of the 16 staff did not have specific symptoms on the line lists. Symptoms include: ill, sick, cold s/sx, GI (gastrointestinal,) and possible allergic reaction. These are not specific symptoms. The Date of Last Symptom dates were left blank on the staff line list for 1 resident in March. Note: Without date of last symptom the return-to-work dates cannot be determined. The February 2024 staff line list contains 27 staff call ins. 9 of 27 staff did not have specific symptoms on the line lists. Symptoms include: sick, not feeling well, upper respiratory, and ill. These are not specific symptoms. The Date of Last Symptom dates were left blank on the staff line list for 2 residents in February. Note: Without date of last symptom the return-to-work dates cannot be determined. The January 2024 staff line list contains 35 staff call ins. 6 of 35 staff did not have specific symptoms on the line lists. Symptoms include: upper respiratory s/sx, GI, In ER (emergency room) all night-no specific, other, doesn't feel well, and sick. These are not specific symptoms. The Date of Last Symptom dates were left blank on the staff line list for 1 resident in January. Note: Without date of last symptom the return-to-work dates cannot be determined. Example 2 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility COVID Outbreak Summary for December does not provide accurate information. The COVID end date is inaccurate. Facility identified outbreak being over 12/30/24 with isolation ending. A resident tested positive 12/19/24 and then a staff tested positive 13 days later. Staff continued to test positive from January through April with last staff testing positive on 4/26/24. May 10th would have ended outbreak with no positive tests from 4/26/24 until 5/10/24. Outbreak summary did not include what interventions went into place and when medical director was notified. The outbreak summary did not include when and how residents, staff, and families were notified of outbreak. On 6/13/24 at 9:03AM, Surveyor interviewed DON B (Director of Nursing) and IP G (Infection Preventionist.) Surveyor asked IP G if something I ate, ill, not feeling good, or cold sx are specific sx. IP G indicated no; they could be more specific. Surveyor asked if specific symptoms should be on the staff line lists and IP G indicated yes. Surveyor asked IP G if Date of last symptom dates should be on the line lists and IP G indicated yes, they should be on there to determine the return-to-work dates. Surveyor asked IP G looking at COVID line list and Outbreak Summary if the end date or isolation end date is accurate and IP G confirmed that the outbreak continued into April with last staff testing positive on 4/26/24 and outbreak would have ended May 10th. Surveyor mentioned to IP G Outbreak Summary should include details such as when medical director was notified, interventions put into place and when, and if public health was notified and when.