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	08/07/2025

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

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that residents receive treatment and care in accordance with professional standards of practice for 1 or 16 residents (R9) reviewed for change of condition.R9 went to the hospital for evaluation following a fall from bed. R9 sustained fractures (fx) of left clavicle (collar bone) and left ribs 3-6 and nursing assessments were not performed on return to the facility. Evidenced by:The facility's Fall Prevention and Management policy, dated 2/28/25, states, in part: . Definitions Fall: The Centers for Medicare and Medicaid Services (CMS) defines a fall as an unintentional change in position that results in someone landing on the ground or a lower surface. Procedure .6. Responding to a fall .l. Follow up assessments of the resident will be completed no less than the next 3 consecutive shifts. m. All assessments will be documented in the E.H.R. (electronic health record) with vital sign collection.R9 admitted to the facility on [DATE] and has diagnoses that include, in part: Multiple Sclerosis (a disease that causes breakdown of the protective covering of nerves, which can cause weakness and lack of coordination); dementia (decline in mental ability severe enough to interfere with daily life); muscle weakness; cognitive communication deficit (difficulty in communication caused by cognitive process rather than speech or language issues).R9's Minimum Data Set (MDS), dated [DATE], indicate a Brief Interview of Mental Status (BIMS) score of 4, indicating moderate cognitive impairment.R9's Progress Notes state, in part:*11/29/24 11:46 AM Writer was called to assess the resident at approximately 9:46 AM d/t (due to) a fall out of bed.*11/29/24 1:51 PM .A CT (Computed Tomography Scan / CAT scan; a medical imaging procedure that uses Xray and computer technology to create detailed, cross-sectional images of the body) of the head and cervical spine were completed that showed a left clavicle fracture. Xray showed left sided rib fx of 3, 4, 5, 6.*11/29/25 5:38 PM Resident returned to facility around 5:00 PM. Assisted into bed. Sling in place. Resident is to wear sling for comfort and immobilization. Biggest risk is for pneumonia as R9 has 3 broken ribs. Monitor for SOB (shortness of breath) and s/s (signs and symptoms) of pneumonia.*11/30/24 4:01 PM Resident lying in supine position in bed when TL (Team Lead) went into check on her. Resident had left arm in sling. When asked if she was in pain, resident responded yes PRN (as needed) Morphine given at 3:15 PM for comfort. Curing the time writer was in room, encouraged resident to deep breath. Continue to monitor for comfort and continue to reposition resident.R9's Neurological Assessment sheet with start date of 11/29/24 indicates that neurological checks were completed on 11/29/24 at 9:40 AM, 9:55 AM, 10:10 AM, and 10:25 AM. The following dates/times are listed with no assessment documented: 11/29/24 10:55 AM, 11/29/24 11:25 AM, 11/29/24 12:25 PM, 11/29/24 1:25 PM, 11/29/24, 5:25 PM, 11/29/24 9:25 PM, 11/30/24 1:25 AM, 11/30/25 5:25 AM, 11/30/24 9:25 AMR9's Physician's Order Sheet, dated 11/29/24, no time indicated, states D/C (discontinue) neuro checks due to CT scan completed.R9's Emergency Department/Urgent Care Documentation dated 11/29/24, states, in part: .Patient Instructions Patient has a fractured clavicle. Sling is given for this. She also has 3 broken ribs. Biggest risk is pneumonia. Incentive spirometry is recommended. Watch for signs of pneumonia such as cough and fever.On 8/6/25 at 10:15 AM, Surveyor interviewed RN/UM F and asked about nursing assessments following R9's return from hospital evaluation with noted fractures. RN/UM F stated that neurological assessments were discontinued per physician orders, but pain and respiratory assessments should have been completed at least once per shift following resident's return to facility. Surveyor asked if those assessments were completed. RN/UM F stated no, there were no assessments documented until 4:01 PM the following day.On 8/6/25 at 4:02 PM, Surveyor interviewed DON B and asked about assessments for R9 following her hospital evaluation with noted fractures. DON B indicated assessments were not completed and should have been done once per shift.

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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	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that the resident environment remains as free of accident hazards as is possible for 1 or 6 residents (R9) reviewed for falls. R9 had a fall from bed, sustaining fractures (fx.) of left clavicle (collar bone) and left ribs 3-6, when CNA J (Certified Nursing Assistant) rolled R9 away from CNA J while performing cares. The facility did not have contemporaneous evidence CNA J, an agency CNA, received education to prevent future incidents from occurring. Evidenced by: The facility's Fall Prevention and Management policy, dated 2/28/25, states, in part: .Definitions Fall: The Centers for Medicare and Medicaid Services (CMS) defines a fall as an unintentional change in position that results in someone landing on the ground or a lower surface. Procedure .6. Responding to a fall .o. The RN Unit Manager will review and discuss trends, follow-up action, and educate staff. R9 admitted to the facility on [DATE] and has diagnoses that include, in part: Multiple Sclerosis (a disease that causes breakdown of the protective covering of nerves, which can cause weakness and lack of coordination); dementia (decline in mental ability severe enough to interfere with daily life); muscle weakness; cognitive communication deficit (difficulty in communication caused by cognitive process rather than speech or language issues). R9's Minimum Data Set (MDS), dated [DATE], indicate a Brief Interview of Mental Status (BIMS) score of 4, indicating moderate cognitive impairment, and indicates a rolling left to right score of 01-dependent (needs full assistance). R9's Care Plan states, in part: Problem Potential for Injury Trauma-falls r/t (related to) unstable condition r/t disease process AEB (as evidenced by): weakness, impaired sense of balance, may have altered sense of safety awareness, may display restlessness, may be agitated, medication effects, potential for altered mental status, may be impulsive, non-ambulatory.Approach 2 assist for incontinence cares and LB (lower body) cares when in bed. Edited 12/3/24. R9's Progress Notes state, in part: *11/29/24 11:46 AM Writer was called to assess the resident at approximately 9:46 AM d/t (due to) a fall out of bed. *11/29/24 1:51 PM .A CT (Computed Tomography Scan / CAT scan; a medical imaging procedure that uses x-ray and computer technology to create detailed, cross-sectional images of the body) of the head and cervical spine were completed that showed a left clavicle fracture. x-ray showed left sided rib fx. (fractures) of 3, 4, 5, 6. R9's Resident Incident/Accident Worksheet, undated, states, in part: Date and Time of Incident 11/29/24 9:40 AM. Name of staff reporting incident: CNA J. Other staff involved/witnesses: n/a (not applicable); Incident type: rolled out of bed; .Behaviors that may have contributed to the injury: staff turned her away from them and she was too close to edge of bed when turned and fell out of bed . R9's Event Report, dated 12/2/24, states, in part: . Date/Time of Occurrence 11/29/24 9:40 AM. Type of Fall-rolled out of bed (fall) . Conclusion and Notifications-Cause: staff rolled resident away from them during cares instead of towards them and didn't take 2 staff in to do cares. Intervention to prevent reoccurrence: 2 staff to do cares when in bed at all times. Agency Employee Logs for CNA J indicate the following dates worked with start time 6:00 AM and end time 2:15 PM: 11/29/24, 12/2/24, 12/3/24, 12/4/24, 12/6/24, 12/7/24, 12/8/24, 12/11/24, 12/12/24, 12/13/24, 12/16/24 On 8/4/25 at 11:07 AM, Surveyor interviewed FM K (Family Member) during initial screening. FM K stated they sat R9 up in bed and left R9 at the edge of the bed and R9 fell and broke ribs. On 8/6/25 at 8:17 AM, Surveyor interviewed CNA E (Certified Nursing Assistant) and asked how many staff members are needed when assisting a resident with care in their bed. CNA E stated usually 2, but for some residents it can be done solo. Some residents have 2 assist listed on their care card. CNA E stated that when working solo, CNA E will try to roll residents toward her, but sometimes you need to roll them away to be able to wash the resident thoroughly if this is the case staff need to bring the resident closer to them to make a bit more room on the bed when rolling a resident away from you. On 8/6/25 at 8:38 AM, Surveyor interviewed RN/IC H (Registered Nurse / Inservice Coordinator) who indicated that if staff are turning a resident in bed for cares, the resident should be turned toward something to protect them, yourself or another staff member. On 8/6/25 at 10:15 AM, Surveyor interviewed RN/UM F (Registered Nurse /Unit Manager) about R9's fall. RN/UM F stated CNA J turned R9 toward the window (away from staff), not sure if she turned her back or left to get supplies. RN/UM F stated RN/UM F spoke with CNA J and got a statement on 12/3/24. Surveyor asked if education was completed and documented. RN/UM F provided a household in-service record dated 12/4/24. Important to note: the 12/4/24 in-service is not signed by CNA J. On 8/6/25 at 4:02 PM, Surveyor called CNA J. Surveyor was unable to reach CNA J and was unable to leave a message on CNA J's voicemail as the voicemail indicated it was full. Surveyor did not receive a return call from CNA J. On 8/6/25

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that a resident maintains acceptable parameters of nutritional status and is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet for 1 of 16 residents (R2) reviewed for nutrition.R2 was not weighed weekly for four weeks from time of admission and did not have a reweight when there was a loss of 9.8 pounds one month after admission. A nutritional supplement was ordered for R2 and was not routinely documented.As evidenced by: The facility's Nutritional Assessment and Care Planning policy, dated 3/20/23, states, in part: Realizing the importance of good nutrition in promoting optimal health and to identify problems which impact nutritional status, facility conducts nutritional assessment of all residents within 5 to 14 days of admission and at least quarterly or more often as needed and develops an individualized plan of care for each resident. Procedure . Weight .a. Weight is to be measured within 24 hours of admission, weekly while on Medicare or for at least one month and until weights are stable for other admissions, or more frequently as determined to be necessary.b. If weight varies by more than 4# (pounds) from previous weight, a reweight must be obtained within 48 hours. c. Amount of weight loss or gain is noted and whether it is planned or not, along with an evaluation of the source of the weight change (diuresis, poor appetite, fluid overload, etc.) .5. Need for, appropriateness, acceptance, and tolerance of therapeutic and mechanically altered diets, with referral to other disciplines as necessary. Use of nutritional supplements and appropriateness of them. A therapeutic diet is defined as a diet ordered to manage problematic health conditions and refers to alteration in nutritional content of foods (including the provision of nutritional supplement during meals which alter the nutritional content of the diet). R2 admitted to the facility on [DATE] and has diagnoses including: dementia with mood disturbance (a decline in mental ability severe enough to interfere with daily life); breakdown of internal fixation device of bone in right lower leg (a mechanical failure or malfunction of the hardware used to stabilize a bone fracture); depression; anxiety disorder; Type 2 Diabetes Mellitus (a condition where the body either doesn't produce enough insulin or cannot properly use the insulin it produces, leading to elevated blood sugar levels); Crohn's disease of both small and large intestine (a chronic inflammatory bowel disease that can lead to diarrhea, abdominal pain, weight loss, and fatigue).R2's MDS (Minimum Data Set) dated 7/22/25, indicates a BIMS (Brief Interview of Mental Status) score of 6, indicating severe cognitive impairment.R2's Physician Orders include: *Ensure or supplement of choice at breakfast and at supper. start date 7/17/25 end date 8/6/25*Ensure or supplement of choice at lunch.start date 7/18/25 end date 8/6/25*Give Glucerna at meals: document under intake supplement (lunch) start date 7/31/25 end date 8/6/25*Give Glucerna if eats less than 50% of meal: document under intake supplement (breakfast and supper) start date 6/17/25 end date 7/31/25R2's Progress Notes include:*4/22/25 Nutrition admission Assessment.Wt. (weight) 4/14/25 207.2# .Appetite: resident with regular diet and tolerating meals with fair to good intake (51-100%) at most meals x 10 since admit, poor intake (1-50%) x 6.Assessment: Resident at moderate nutrition risk due to age, diagnosis, past medical history, regular diet and fair to good intake at most meals. Will monitor intake and appetite, progress, labs, weight and follow up with recommendation as needed.*7/17/25 Nutrition Assessment.Wt: 7/13/25 190.3#, 6/15/25 192.8#, 5/18/25 197.4#, 4/14/25 207.2# . Assessment: Resident at moderate to high nutrition risk due to age, diagnoses, past medical history, Regular diet with varied intake at most meals, breakfast seems to be the best at 76-100%. Current weight loss of 16. 9# since admit. Will send a referral to nursing to offer Ensure with lunch and supper.*7/18/25 Nutrition Follow up: New order for Ensure or nutrition supplement of choice with meals TID (three times a day) due to weight loss. Will continue to monitor weight.R2's Vitals report indicates the following weights:*4/14/25 207.2 lbs (pounds)*5/18/25 197.4 lbs*6/1/25 193.4 lbs*6/8/25 193.4 lbs*6/15/25 192.8 lbs*6/29/25 193.6 lbs*7/6/25 192.8 lbs*7/13/25 190.3 lbs*7/20/25 190.6 lbs*8/1/25 187.4 lbsImportant to note: there is no documentation of a reweight following the 5/18/25 weight. R2's Vitals report indicates the following documentation for Supplements:*5/1/25 12:26 PM Supplements 240 ml Amount 76-100%*7/1/25 9:49 PM Supplements Amount 76-100%*7/6/25 12:08 PM Supplements Amount 26-50%*8/5/25 12:58 PM Supplements Not Taken: Refused*8/6/25 8:38 AM Supplements Not Taken: RefusedImportant to note that supplement was ordered for three times daily (scheduled) from 7/18/25 through 8/6/25 for a total of 57 times. In that time frame supplements were documented as offered on two occasions. R2's Vitals report indicates that meal intakes were documented as 1-25% or less, as follows:Breakfast:4/27/25 5/15/25 6/6/25, 6/7/25, 6/8/25, 6/21/25