

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525458	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2025
NAME OF PROVIDER OR SUPPLIER Park View Home		STREET ADDRESS, CITY, STATE, ZIP CODE 220 Lockwood St Woodville, WI 54028	

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)
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47807</p> <p>Based on interview and record review, the facility did not ensure a thorough investigation was conducted to prevent further abuse for 1 of 3 residents (R) R2 reviewed for abuse.</p> <p>-The facility did not thoroughly investigate to rule out abuse to other residents. No interviews were conducted with other residents to ensure there had been no further incidents of abuse.</p> <p>Findings include:</p> <p>The facility policy titled, Abuse Prevention/ Resident Safety that was reviewed on 04/15/24, states, in part:</p> <p>Response</p> <p>Upon receiving information concerning a report of abuse, the administrator, or designee, will immediately initiate a thorough investigation to include the following details of the incident:</p> <p>In the event of a Resident-to-Resident altercation, staff will implement the following:</p> <p>3. Conduct an internal investigation to include investigating the situation, including identification of witnesses, interviewing people involved or with knowledge of the situation.</p> <p>R2 was admitted to the facility on [DATE] with diagnoses that include Alzheimer's, anxiety, and localized edema. R2 was not considered their own person and had an activated POA. The facility determined that R2 was no longer able to consent for sexual interactions.</p> <p>R2's most recent MDS performed on 12/17/24 indicated that R2 had a brief interview for mental status (BIMS) score of 4 out of 15, which indicates cognitive impairment.</p> <p>R1 is a member of the assisted living community that is attached to the skilled nursing facility. Members of the assisted living community utilize a dining area that is located on the skilled nursing side of the building. Members of the assisted living community also attend activities on the skilled nursing facility community areas.</p> <p>(continued on next page)</p>

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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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Surveyor reviewed the facility's investigation, completed on 01/10/25, into the sexual abuse of R1 to R2. On 01/06/25, R1 kissed R2 on the mouth without proper consent. The facility did not have any documentation in which other residents that R1 would have had access to were interviewed. There was no evidence in the report that the facility had ensured other residents had no contact with R1.</p> <p>On 01/23/24 at 11:07 AM, Surveyor interviewed R3 and asked if the facility had approached them in the last month and done any type of interviewing regarding other residents. R3 said they had not.</p> <p>On 01/23/24 at 11:07 AM, Surveyor interviewed R4 and asked if the facility had approached them in the last month and done any type of interviewing regarding other residents. R4 said they had not.</p> <p>On 01/23/24 at 12:32 PM, Surveyor interviewed Director of Nursing (DON) B regarding the investigation into R1 kissing R2 on the mouth. DON B explained that R1 had a history with another resident and during that relationship R1 and the other resident needed to stop seeing each other due to a reduction in cognition level of the other resident. R1 understood and then sometime later the relationship with R2 started and they believed that they knew R1's patterns and that R1 gave no indication that they needed to investigate other residents. They had never seen R1 in another resident's room although he did visit a male friend from time to time who lived in the skilled nursing facility. DON B believed that R1 was not left alone in the long-term care, and they had not seen R1 entering other female residents' rooms.</p> <p>On 01/23/24 at 12:45 PM, Surveyor interviewed Nursing Home Administrator (NHA) A regarding the investigation and missing resident interviews. When asked if the facility interviewed residents to ensure no one else was affected or targeted, NHA A said no they didn't. NHA A reiterated they did not feel it was necessary in this situation. They removed R1 immediately and did not allow them back to the skilled nursing facility. NHA A also said they knew R1's history and tendencies, and due to that they felt the residents were safe.</p>		