STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525461	A. Building B. Wing	10/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pavilion at Glacier Valley	1900 American Eagle Dr Slinger, WI 53086

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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. (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 0849 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 staff interview and record review, the facility did not ensure Hospice services during end of life care were coordinated for 1 resident (R1) of 2 sampled residents.On the 9/6/25 AM shift, Hospice Registered Nurse (HRN)-C informed Certified Nursing Assistant (CNA)-E that R1 was actively passing and should not be gotten out of bed. The information was not communicated to PM or night shift staff. R1 was gotten out of bed in accordance with R1's routine by night shift staff who were unaware that R1 was actively passing. Findings include:The facility's Hospice Care policy, dated 5/5/23, indicates: Procedures: .4. To provide continuity of care, the Hospice, nursing home, and resident/representative must collaborate in the development of a coordinated care plan which includes but is not limited to, the following: Interventions that address, as appropriate, the identification of timely, pertinent non-pharmacologic and pharmacologic interventions to manage pain and other symptoms of discomfort .8. The facility and Hospice provider will have ongoing collaborative communication. Facility staff must immediately contact and communicate with Hospice staff and the resident's family and/or legal representative any significant changes in the resident's status, clinical complications, or emergent situations. These situations may include but are not limited to changes in condition or a sudden unexpected decline in conditin .The facility's Hospice contract for Hospice Company (HC)-F, dated 4/22/19, indicates: Coordination of Services: Hospice and facility will immediately inform the other of any change in the condition of the Hospice patient including, but not limited to, i. A significant change in the Hospice patient's physical, mental, social, or emotional status; ii. Clinical complications appear that suggest a need to alter the plan of care .On 10/8/25, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including unspecified dementia, wedge compression fracture of first lumbar vertebra, subsequent encounter for fracture with routine healing, and pain. A Minimum Data Set (MDS) assessment completed 8/28/25 had a Brief Interview for Mental Status (BIMS) score of 8 out of 15 which indicated R1 had moderate cognitive impairment. R1 had an activated Power of Attorney for Healthcare (POAHC). R1 started Hospice services with HC-F upon admission to the facility. R1 passed away at the facility on 9/7/25. A Hospice note, dated 9/6/25 at 8:55 AM and written by HRN-C, indicated HRN-C met R1 and R1's family in the common area. R1 was in a wheelchair drinking coffee. R1's family indicated R1 was more responsive that morning and they wanted to get R1 out of bed for a while. R1 struggled to stay awake during the visit and was unable to hold R1's head up or hold a coffee cup without assistance. Mottling was noted on R1's arms, knees and lower legs and R1's extremities were cool. When asked if R1 wanted to lay down, R1 mumbled yes. R1's pain was at a level 0 out of 10 at rest; however, R1's pain increased to a level 5 out of 10 with the Hoyer transfer to bed as evidenced by R1 moaning, grimacing, and guarding R1's stomach. All routine medications were discontinued. Comfort meds only were to be given. On 10/8/25 at 12:40 PM, Surveyor interviewed HRN-C via phone. HRN-C saw R1 on the morning of 9/6/25 for an end of life daily visit. R1's family had R1 up when HRN-C arrived. HRN-C indicated to staff in the room (who HRN-C thought was Licensed Practical Nurse (LPN)-D but was actually CNA-E who was also a Medication Technician) that if R1 had a rally moment, it would be appropriate to get R1 up but otherwise R1 should remain in bed. R1 was responsive during HRN-C's visit. HRN-C indicated LPN-D (who was actually CNA-E) was in the room for a period of time. Stopping medications and feeding and focusing on comfort was discussed. R1 appeared comfortable at the beginning of the assessment but expressed pain when laid flat. An assessment indicated the pain was due to urinary issues. HRN-C had not ordered any scheduled medications for R1 at that point. R1 had orders for as needed (PRN) comfort pain medications.On 10/8/25, Surveyor attempted to contact LPN-D and CNA-E with no return phone calls.On 10/8/25 at 2:22 PM, Surveyor interviewed CNA-G who worked the 9/6/25 PM shift. CNA-G indicated CNAs do a 1:1 shift report; however, CNA-G could not find CNA-E for shift report that afternoon and was not told that R1 was actively passing and should remain in bed. CNA-G did not get R1 out of bed during CNA-G's shift. CNA-G indicated R1's family visited most of the shift and it didn't look like R1 should get out of bed. CNA-G informed night shift CNA-H that R1 didn't eat anything and had 50 cubic centimeters (ccs) of output in R1's catheter. On 10/8/25, Surveyor attempted to contact CNA-H with no return phone call. On 10/8/25 at 12:30 PM, Surveyor interviewed LPN-I who worked the night shift from 9/6/25 into 9/7/25. LPN-I indicated neither LPN-I or CNA-H were informed that R1 was actively passing. LPN-I indicated R1 slept all night and appeared comfortable. LPN-I and CNA-H got R1 up in the morning per usual as R1 was usually gotten up on the night shift. LPN-I