STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525497	A. Building B. Wing	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Pines Post Acute and Memory Care	1625 E Main St Clintonville, WI 54929

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on staff interview and record review, the facility did not implement written policies and procedures that prohibit and prevent abuse for 1 (Certified Nursing Assistant (CNA)-C) of 8 staff reviewed for caregiver background checks. The facility did not ensure a thorough caregiver background check was completed for CNA-C. Findings include: The facility's Abuse Prevention Program, dated 5/2025, indicates: It is the policy of this facility that each resident has a right to be free from abuse, neglect, misappropriation of resident property, and exploitation . Residents must not be subjected to abuse by anyone, including but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident .2. All employees will be properly screened for criminal background at a minimum of on hire and every four years . Wisconsin Caregiver Program: Offenses Affecting Caregiver Eligibility For Chapter 50 Programs, dated 4/2020, indicates: This document lists Wisconsin crimes and other offenses that the Wisconsin State Legislature, under the Caregiver Law, Wis. Stat. § 50.065, has determined require rehabilitation review approval before a person may receive regulatory approval, work as a caregiver, reside as a non-client resident at, or contract with an entity .Additional information must be obtained when: .The Background Information Disclosure (BID) or Department of Justice (DOJ) response indicates a conviction of any of the following, where the conviction occurred five years or less from the date on which the information was obtained .6. Disorderly conduct Wis. Stat. § 947.01 .Note: These seven convictions do not prohibit employment, but do require the entity to obtain the criminal complaint and judgment of conviction from the Clerk of Courts office in the county where the person was convicted . On 6/19/25, Surveyor reviewed background check information for 8 facility staff, including CNA-C, and noted CNA-C was a contracted CNA whose hire date was listed as 10/1/24. CNA-C's BID form was dated 1/13/25. The facility did not provide CNA-C's Wisconsin DOJ criminal background check letter or Integrated Background Information System (IBIS) letter. An Attestation Notification indicated CNA-C's agency no longer provided copies of background check results due to an increased focus on privacy laws, federal and/or state regulations, the Fair Credit Reporting Act, restrictions set forth by contracts, and increased focus on joint employer liability. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525497	A. Building B. Wing	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Pines Post Acute and Memory Care	1625 E Main St Clintonville, WI 54929

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/19/25 at 2:57 PM, Surveyor interviewed Human Resource Manager (HRM)-D who indicated staffing agencies provide the facility's scheduler with agency staff members' criminal background check information and the scheduler sends the information to HRM-D who keeps files on all agency staff. When asked about the DOJ and IBIS letters for CNA-C, HRM-D indicated the agency that CNA-C worked for no longer provides criminal background check documents to the facility due to a data breach. On 6/19/25 at 3:18 PM, Surveyor interviewed Agency Manager (AM)-E via phone who verified AM-E was the manager of the agency that employed CNA-C. AM-E indicated the agency does not provide criminal background check information to facilities in order to protect the privacy of agency employees. During the interview, AM-E emailed CNA-C's DOJ and IBIS letters to Surveyor. With AM-E on the phone, Surveyor reviewed CNA-C's DOJ letter, dated 1/16/25, and IBIS letter, dated 1/16/24. The DOJ letter indicated CNA-C was charged with Disorderly Conduct Wis. Stat. § 947.01(1) in 2021. The charge was dismissed and CNA-C was instead convicted of Disorderly Conduct Wis. Stat. § 31.02(1). AM-E was unaware of the Wisconsin Caregiver Program: Offenses Affecting Caregiver Eligibility For Chapter 50 Programs document and indicated the agency has its own hiring standards which do not include a detailed review of Disorderly Conduct Wis. Stat. § 947.01 if an agency staff is convicted of such.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525497	A. Building B. Wing	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Pines Post Acute and Memory Care	1625 E Main St Clintonville, WI 54929

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 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** 2. On 6/19/25, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] and had a diagnosis of Parkinson's disease. R2's MDS assessment, dated 5/2/25, had a BIMS score of 9 out of 15 which indicated R2 had moderate cognitive impairment. R2 had a POAHC. R2's care plan indicated the following: ~ Sensor alarm to bed and chair to alert staff of self-ambulating so staff can assure R2 is using R2's walker ~ Do not put feet up in recliner, unable to put down independently Surveyor reviewed a fall investigation that indicated R2 was found on the floor of R2's room on 4/27/25 at 6:15 PM. CNA staff had assisted R2 to bed less than five minutes prior. A Licensed Practical Nurse (LPN) entered R2's room to administer medication at 6:15 PM and observed R2 ambulating independently in the room and bleeding above the right eye. The bed alarm was not sounding when the LPN entered the room. R2 was unable to state what occurred but reported that R2 fell. R2 was transferred to the emergency room (ER) for evaluation. It was determined that staff did not turn on the bed alarm when they assisted R2 to bed. The Interdisciplinary Team (IDT) reviewed the incident and verified that failure to follow R2's care plan resulted in the lack of immediate notification of R2's fall although R2 was discovered shortly afterward. The fall resulted in the reopening of a prior cut that needed to be resutured (stitches were removed from R2's right eye on 4/26/25). Immediate education was provided to the staff who did not follow R2's care plan and education was provided to all staff in the following days. The investigation included an interview with CNA-F who indicated R2 was toileted prior to being assisted to bed. CNA-F was aware that R2 needed a chair alarm but not a bed alarm. The investigation also included an interview with CNA-G who indicated R2 was toileted prior to being assisted to bed. CNA-G was not aware that R2 needed a bed alarm. On 6/19/25 at 9:35 AM, Surveyor observed a staff assist R2 into R2's recliner. Surveyor heard the alarm pad beep twice as R2 sat in the recliner. The staff ensured R2's call light was within reach and exited the room. On 6/19/25 at 9:37 AM, Surveyor observed R2 stand up from the recliner and heard the alarm sound. RN-H and LPN-I immediately responded and assisted R2 back into the recliner. Surveyor observed RN-H raise the footrest of the recliner and ensure R2's call light was within reach. RN-H and LPN-I then exited the room. On 6/19/25 at 9:58 AM, Surveyor interviewed DON-B who showed Surveyor the Kardex behind R2's door. DON-B verified the Kardex indicated the footrest of the recliner should not be raised. DON-B verified R2's footrest was in a raised position and lowered R2's footrest for safety. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525497	A. Building B. Wing	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Pines Post Acute and Memory Care	1625 E Main St Clintonville, WI 54929

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 0689 Level of Harm - Actual harm Residents Affected - Few	On 6/19/25 at 10:08 AM, Surveyor interviewed RN-H who verified RN-H responded to R2's alarm and raised the footrest on R2's recliner. RN-H did not realize R2's care plan indicated the footrest should not be raised. RN-H was aware care plan interventions were listed in the computer and on the back of room doors. RN-H verified staff had received education a couple months ago regarding falls and the importance of following care plan interventions. Based on observation, staff interview, and record review, the facility did not ensure fall prevention interventions were in place for 2 residents (R) (R1 and R2) of 5 sampled residents. R1's care plan contained interventions for bed and chair alarms for fall prevention. On 5/16/25, staff did not ensure R1 had a wheelchair alarm and R1 fell. On 5/26/25, staff did not ensure R1 had a bed alarm. R1 fell while attempting to get out of bed. On 6/7/25, staff did not ensure R1 had a wheelchair alarm. R1 self-transferred, fell, and sustained a hip fracture that required hospitalization. (This example is being cited at a level G.) R2's care plan contained interventions for bed and chair alarms for fall prevention. On 4/27/25, staff did not ensure R2 had a bed alarm. R2 fell and reopened a suture line on R2's forehead sustained in a previous fall. In addition, R2's care plan indicated R2 was not to have the footrest raised while in R2's recliner. On 6/19/25, staff raised the footrest while R2 was in the recliner. Findings include: The facility's Falls Program policy, dated 4/2025, indicates: It is the policy of this facility to reduce the number and severity of falls and to identify high risk residents and take precautionary measures .3. Staff to check at beginning of every shift for correct application of care planned interventions (i.e., alarms, floor mats, call light within reach, restraints, wheelchairs, bed rails, etc.) . 1. On 6/19/25, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including dementia, chronic multifocal osteomyelitis in right ankle and foot, and diabetes. R1's Minimum Data Set (MDS) assessment, dated 5/20/25, had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated R1 had intact cognition. R1 had an activated Power of Attorney for Healthcare (POAHC). A care plan (initiated 5/15/25) indicated R1 was at risk for falls related to weakness and multiple sclerosis and contained the following intervention: Fall prevention devices per orders and/or per Kardex (an abbreviated care plan used by nursing staff) - chair alarm and bed alarm due to impulsiveness, does not always ask for assistance (initiated 5/19/25). A care plan (initiated 5/15/25) indicated R1 had an activities of daily living (ADL) self-care performance deficit related to multiple sclerosis and contained the following intervention: Transfer: Two assist pivot transfer with gait belt and walker (initiated 5/15/25). A care plan (initiated 6/1/25) indicated R1 was on diuretic therapy related to hypertension (high blood pressure) and contained the following interventions: May cause dizziness, postural hypotension (low blood pressure), fatigue, and an increased risk for falls. Observe for possible side effects (every) shift (initiated 6/1/25); Monitor for increased falls with position changes (initiated 6/1/25). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525497	A. Building B. Wing	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Pines Post Acute and Memory Care	1625 E Main St Clintonville, WI 54929

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 0689 Level of Harm - Actual harm Residents Affected - Few	A progress noted, dated 6/7/25 at 12:45 PM, indicated the writer was called to R1's room by an activity staff who was in the hallway and heard noise from the room. R1 was observed on the floor on R1's left side with R1's legs in the bathroom and upper body in the bedroom. R1's walker was between the bed and the doorway and R1's wheelchair was next to the recliner. R1 had a hematoma and was bleeding from the left side of the head at the hairline. R1 reported head pain but denied arm and leg pain. R1 later complained of upper left thigh pain when sitting in the wheelchair. The on-call provider was notified and R1 was sent to the Emergency Department (ED). On 6/19/25, Surveyor reviewed a facility-reported incident (FRI) that indicated on 6/7/25 at 11:25 AM, Activities Aide (AA)-J witnessed R1 fall. AA-J called for assistance and told Assistant Director of Nursing (ADON)-K what had occurred. ADON-K assisted R1 and notified the on-call doctor at approximately 11:40 AM. Emergency Medical Services (EMS) arrived and transported R1 to the hospital. ADON-K interviewed staff on the unit and discovered R1's care plan was not followed regarding the use of a chair alarm. As a result of the fall, R1 was hospitalized with a hip fracture. Surgical repair was scheduled, however, R1 passed away on 6/11/25 with the cause as death listed as acute encephalopathy (a sudden disturbance in brain function often caused by systemic issues rather than direct brain injury). The fall investigation contained an interview with ADON-K, dated 6/7/25, that indicated ADON-K was notified by activity staff at approximately 11:25 AM that R1 was on the floor in R1's bedroom. ADON-K observed R1 on the floor and noted R1 was bleeding from the head. ADON-K applied pressure to the area and completed a neuro assessment. The bleeding was not controlled and the physician was notified at approximately 11:40 AM. R1 was sent to the ED for evaluation and treatment due to a head injury, anticoagulant use, and upper left thigh pain. ADON-K noted R1's chair alarm/sensor pad was not in the wheelchair and observed a sensor pad on the floor next to R1's recliner with the alarm in the side pocket of the recliner. R1 was last seen in the sun room in a wheelchair. An undated interview with AA-J indicated AA-J was in the hallway on 6/7/25 at approximately 11:30 AM and heard the clinking sounds of a walker bumping into something. AA-J looked in R1's room and saw R1 fall backwards and hit R1's head on the floor. AA-J saw ADON-K at the end of the hallway and notified ADON-K that R1 fell. An interview with Certified Nursing Assistant (CNA)-L, dated 6/11/25, indicated CNA-L had gotten R1 up before breakfast on 6/7/25 and was unaware that R1 should have a chair alarm, but knew R1 had bed an recliner alarms. CNA-L indicated R1 went to the sun room for breakfast and worked on a puzzle in the sun room after breakfast. Prior to lunch, CNA-L went to another wing that needed assistance and was not on the unit when R1 fell. An undated handwritten statement from CNA-L indicated CNA-L thought R1 self-transferred to a rocking chair from R1's wheelchair and then walked to the bathroom. The chair alarm was on the floor and CNA-L saw R1 laying on the floor by R1's bathroom door. On 6/19/25 at 1:50 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B who verified staff did not follow R1's care plan and did not ensure R1 had a chair alarm on 6/7/25. Education was provided to all staff regarding following care plan interventions, however, current noncompliance was observed during the survey. (See example 2)