

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525624	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/25/2025
NAME OF PROVIDER OR SUPPLIER Grand View Care Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 620 Grandview Ave Blair, WI 54616	

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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31086</p> <p>Based on interview and record review, the facility did not ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law for 1 of 1 incidents reviewed.</p> <p>R10 alleged being physically abused by Certified Nursing Assistant (CNA) J on 02/09/25 at 11:00 PM. This was not reported to the state until 02/11/25 at 2:55 PM.</p> <p>This is evidenced by:</p> <p>Review of facility's policy titled Abuse, Neglect, and Misappropriation dated 04/02/23 read in part, All alleged violation involving abuse, neglect .are reported immediately to the State Agency, but not later than two (2) hours after the allegation is made, if the events that cause the allegation involve abuse .</p> <p>R10 was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting right side, anxiety, and depression.</p> <p>R10's annual Minimum Data Set (MDS) dated [DATE] recorded a Brief Interview for Mental Status (BIMS) of 12, which indicates moderate cognitive impairment.</p> <p>On 02/11/25 at 5:45 PM, Surveyor interviewed R10 asking if staff have ever physically abused R10. R10 indicated there was a time I was thrown against the wall. R10 reported to the nurse of the incident. R10 denied having any injuries. R10 could not recall who the staff was and could not remember when the incident occurred. R10 could not recall the specifics to the incident.</p> <p>A facility self report indicates that on 02/09/25 at 11:00 PM, R10 reported to Licensed Practical Nurse (LPN) K that CNA J banged R10's head against the wall during cares.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525624	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/25/2025
NAME OF PROVIDER OR SUPPLIER Grand View Care Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 620 Grandview Ave Blair, WI 54616	

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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>LPN K assessed R10 and did not note any bruising, discoloration, or injuries. R10 denied any pain. LPN K reported immediately to Nursing Home Administrator (NHA) A and Director of Nursing (DON) B. Then LPN K sent CNA J home until the investigation was complete.</p> <p>CNA J reported R10 was verbally abusing CNA J when providing R10 cares. CNA J claimed R10's head did not hit the wall and believes there was a pillow between R10 and the wall.</p> <p>On 02/11/25 at 9:00 AM., Surveyor interviewed NHA A about reporting of the allegation of abuse. NHA A indicated staff reported immediately, within the two hours, to NHA A and DON B and assessed R10 who was found to have no injuries. NHA A went on to say, R10 has a history of not liking certain staff and making derogatory statements of minority staff. NHA A indicated it was determined the allegation of abuse did not occur, and R10 may have hit head on wall when rolled, but there was no injury to conclude R10's head hit the wall.</p> <p>NHA A determined this was not a willful act or an intentional act by CNA J and was not reported to the State agency as abuse. Surveyor asked NHA A if this was determined within the first 2 hours of R10 reporting. NHA A indicated it was not determined within the first 2 hours.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525624	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/25/2025
NAME OF PROVIDER OR SUPPLIER Grand View Care Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 620 Grandview Ave Blair, WI 54616	
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 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31086</p> <p>Based on observation, interview and record review, the facility did not ensure residents received the necessary treatment and services consistent with professional standards, to prevent pressure injuries (PI) from developing and promote healing for 2 of 2 residents (R1 and R2) reviewed for PIs.</p> <p>R1 was admitted to the facility without a PI and was assessed to be at risk for PI development. The facility failed to implement robust interventions to prevent PI development, did not assess or stage the PI weekly and did not update care plan interventions timely. R1 developed a facility acquired PI that worsened to a stage 4.</p> <p>The facility's failure to complete weekly comprehensive PI assessments, offer alternate repositioning schedules, update the care plan and implement interventions for R1 created a finding of immediate jeopardy that began on 01/09/25. Nursing Home Administrator (NHA) A was notified of the immediate jeopardy on 02/13/25 at 12:30 PM. The immediate jeopardy was removed on 02/19/25; however, the deficient practice continues at a scope/severity level D (potential for harm/isolated) as they continue to implement their interventions for residents at risk for PIs and as evidenced by the following example.</p> <p>R2 was admitted to the facility without a PI and was assessed to be at risk for PI development. The facility failed to complete comprehensive assessments, and did not offer alternative interventions or educate R2 on risks and benefits when R2 refused repositioning. R2 developed two deep tissue injuries (DTI) on the right and left buttock on 9/12/24; on 9/20/24 six PIs are identified. The multiple PIs worsened to one unstageable PI with undermining.</p> <p>This is evidenced by:</p> <p>Guidelines from the National Pressure Injury Advisory Panel (NPIAP) Quick Reference Guide 2019 indicate in part: 2.1 Conduct a comprehensive skin and tissue assessment for all individuals at risk of pressure injuries: As soon as possible after admission/transfer to the health care service .5.1 Reposition all individuals with or at risk of pressure injuries on an individualized schedule, unless contraindicated .5.5 Reposition the individual in such a way that optimal offloading of all bony prominences and maximum redistribution of pressure is achieved . NPIAP Classification Unstageable Pressure injury: Obscured full thickness skin and tissue loss. Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed .</p> <p>Example 1</p> <p>R1 was admitted to the facility on [DATE] with diagnoses of osteoarthritis right knee, right shoulder, anxiety disorder, major depression, chronic kidney disease stage 3a, and anemia. There was no evidence that R1 had a PI upon admission.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525624	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/25/2025
NAME OF PROVIDER OR SUPPLIER Grand View Care Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 620 Grandview Ave Blair, WI 54616	
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 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Minimum Data Set (MDS) dated [DATE], an admission assessment, documented brief interview status (BIMS) score of 13 meaning R1 is cognitively intact. R1 has impairment to one side of the upper extremities and both sides of the lower extremities. R1 requires maximum assist from staff for upper body dressing, personal hygiene, transfers and is dependent on staff for toileting, showers, lower body dressing and transfers. R1 had no behaviors of rejection of cares. R1 is at risk for PI and has no PI present on admission. R1's pain is frequent and rated at 8/10.</p> <p>Progress notes documented on 08/01/24 skin problems: Bordered foam removed from coccyx. Previous open area healed. All skin intact.</p> <p>On 08/01/24, an order for Juven supplement 1 packet with 8 oz of water b.i.d. (twice a day) for wound healing.</p> <p>On 08/01/24, the facility completed a Braden pressure injury risk assessment with a score of 17, indicating R1 is at mild risk for skin breakdown.</p> <p>On 08/11/24, a progress note for skin problems; bordered foam to coccyx restarted as area is starting to break down again. Resident denies pain to area. Pressure relief cushion in w/c and recliner. The facility did not complete a comprehensive assessment of the area to include description of the PI, stage of the PI, and measurements.</p> <p>On 08/21/24, a weekly skin assessment documented, Resident was in bathroom when CNA (Certified Nursing Assistant) called this writer to assess coccyx area. Length 1.7 cm, Width 0.9 cm, Tissue Type: Area appears as skin breakdown from top layer of tissue. Area is slightly moist, dressing was not intact. Wound tissue: Dark pink, slightly moist, edges defined. Physician was notified.</p> <p>Of note, this assessment is 10 days after the first PI was noted and the facility did not stage the PI or update the care plan with new PI interventions.</p> <p>Facility did not complete a weekly skin assessment on 08/28/24 to include all components of a comprehensive PI assessment.</p> <p>On 09/06/24, a weekly skin assessment documented 1.7 cm by 1 cm and depth appears to have cratered in, skin around site appears to be 0.3 cm higher than middle of wound bed. Wound bed appears to be covered with greater than 75% pale yellow slough with small amount of sero-sanguineous drainage. Physician was notified. Continue to observe and reposition. Note at this time the PI would be at a stage 3 or higher with slough to the wound bed.</p> <p>On 09/06/24, new treatment order to cleanse coccyx area wound, place collagen to fit wound bed, and cover with bordered foam daily AM.</p> <p>On 09/08/24, a skin problem note documented measurements of 2 cm by 2.5 cm by 0.6 cm at the deepest area, but wound bed is covered with yellow slough. Small amount brown/yellow drainage and no odor. Area cleansed, collagen applied with bordered foam. Education again with resident on moving and walking.</p> <p>Of note, this PI has increased in size.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525624	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/25/2025
NAME OF PROVIDER OR SUPPLIER Grand View Care Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 620 Grandview Ave Blair, WI 54616	
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 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 09/12/24, a late entry weekly skin assessment. Measurements of 2.6 cm by 2.8 cm by 0.4 cm, small hole like area with yellow slough. Moderate amount of pale yellow drainage. Per Gentell wound specialist recommendation, continue collagen to wound bed and into hole like area of wound, cover with super absorbent dressing daily. Resident refuses to lay down to offload pressure from coccyx during the day, prefers to sit in the recliner. Has an equa-gel cushion now in recliner. Encouraged resident to lay down during the day.</p> <p>Of note, this is the first time R1 has seen a wound specialist.</p> <p>On 09/18/24, a weekly skin assessment measurements 2.7 cm by 2.5 cm by 1.5 cm with slough. Wound bed appears as a crater, from what can be visualized that is not covered in pale yellow moist slough less than 90%. Small amount of serous drainage noted to old dressing. Resident was strongly encouraged to stay in bed to stay off of site, but resident is adamant that she needs to sit up. Physician was notified.</p> <p>On 09/26/24, weekly skin assessment measurements 2 cm by 2.5 cm by 1.5 cm with pale yellow slough and moist pink tissue noted at wound bed. Physician was notified, continue to observe, repositioned, infection control RN (Registered Nurse) replaced current cushion (equa-gel) with a taller equa-gel cushion that is 2.5 tall to give more support for offloading pressure.</p> <p>On 10/04/24, a skin problem note documented wound rounds were done with Gentell wound specialist on 10/03/24. Coccyx stage 3 measurements 2.7 cm by 2 cm by 0.8 cm with granulation tissue. Pressure relieving interventions in place, recently added to her recliner was a Equagel Protector cushion 2.5, air mattress with pump (this was added on 08/29/24), repositioning every 2 hours as resident allows, and use of wedges and pillows. She also takes Juven BID in AM/PM to promote wound healing. Collagen packed into wound bed and covered with a super absorbent dressing and all sides secured with silicone tape. Education has been provided to resident by this writer on the importance of repositioning.</p> <p>Of note, the positioning schedule of every 2 hours added on 10/4/24 is not current standard of practice for repositioning with a PI on the coccyx.</p> <p>On 10/03/24, a new treatment order to cleanse coccyx area, pack a 2x2 collagen (folding) into wound bed, skin prep to intact surround skin, cover with a super absorbent dressing, and secure all edges of dressing with silicone tape to prevent stool from undermining dressing every three days and as needed AM.</p> <p>The facility did not complete a weekly skin assessment that covers a comprehensive assessment of a PI on 10/11/24.</p> <p>On 10/18/24, skin problem note documented measurements of 2 cm by 2.4 cm by 0.9 cm with slough. Undermining present from 9 o'clock - 1 o'clock of wound bed measuring 1.5 cm at this time. Small amount of light gray-yellow drainage noted. Informed resident the area is not improving and needs to offload pressure from site. Physician was notified.</p> <p>Of note, this PI has now worsened with undermining and the facility has not staged the PI since first identified and did not add new PI interventions to the care plan when the PI is worsening.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525624	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/25/2025
NAME OF PROVIDER OR SUPPLIER Grand View Care Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 620 Grandview Ave Blair, WI 54616	
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 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 10/25/24, weekly skin assessment measurements of 2 cm by 2.1 cm by 1 cm with pale white-yellow slough at base of wound. Undermining 9 o'clock - 1 o'clock of wound bed measuring 1.5 cm. Small amount of serosanguineous drainage noted. Treatment hydraferra blue dressing to fit wound bed, skin prep to surrounding area and cover with absorbent dressing and secure with silicone tape. Physician was notified. Added to care plan to use pillow in recliner to offload pressure from coccyx while in chair.</p> <p>Of note, using a pillow will compress and would not be an effective offloading device. Again, the facility did not stage the PI. Consistently staging the PI is important in determining if interventions are successful or if interventions need to be altered.</p> <p>On 10/25/24, a new treatment order. Remove old dressing to coccyx area, including old hydra-[NAME] blue dressing at wound bed. Cleanse wound with wound cleanser. Use cotton tipped applicator to rub very inner edges at surface of wound as intervention to epibole effect. Cut new hydra-[NAME] blue dressing to fit wound bed, re-hydrating it with normal saline and squeezing out the excess. Place on wound bed base. Place skin prep to intact surround skin, cover with a super absorbent dressing, and secure all edges of dressing with silicone tape to prevent stool from undermining dressing every three days and as needed.</p> <p>Care plan dated 11/08/24 documented, I didn't meet my goal because: has area to the coccyx that is being treated as current area open with slough 2cm by 2.1cm and depth 1cm in size on coccyx My goal remains appropriate. Continue my goal for 3 months. 01/21/25 I need to reposition frequently and reminders to reposition often, to keep pressure off of the coccyx area. I need my aides to help me with hygiene and general skin care .help me reposition at least every 1-2 hours while I'm in bed help me reposition at least every 1 hour when I'm in a chair and not to sleep in my chair .Goal Time: Three months. (08/29/24 air mattress with pump, 09/28/24 Equagel Protector cushion - 2 .5 to w/c and recliner, (Equagel cushion is adequate for all stages) 10/25/24 use pillow at either side (one or the other) while in recliner to offload pressure from coccyx area, 01/09/25 limit time in recliner and do not sleep in recliner, off load pressure to the wound on coccyx follow up with wound clinic as needed.</p> <p>Of note, this is the first care plan related to skin integrity.</p> <p>On 11/01/24, a new order for Med Pass 2.0 a food supplement to be given at AM and PM. Of note, this is the last updated nutritional intervention for R1.</p> <p>On 11/10/24, a weekly skin assessment measurements 2.2 cm by 2.1 cm by 0.9 cm with white/yellow slough, undermining remains measuring 1.5 cm. small amount of brown drainage noted. There was no evidence that staff documented the stage of the PI during this assessment. The physician was not updated with the increase in size.</p> <p>On 11/15/24, a weekly skin assessment measurements 2 cm by 1.9 cm by 1.1 cm with white/pale yellow slough at center, undermining noted to approximately 11 o'clock measuring 1.4 cm. Small amount of pale yellow drainage. Physician was notified. Resident encouraged to off load pressure from site by laying on sides, even when in recliner to try and offload pressure.</p> <p>Of note, the PI is worsening with undermining and drainage. New PI interventions are not added to the care plan to promote healing.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525624	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/25/2025
NAME OF PROVIDER OR SUPPLIER Grand View Care Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 620 Grandview Ave Blair, WI 54616	
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 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 11/21/24, a weekly skin assessment measurements 2.1 cm by 1.9 cm by 0.9 cm with scattered white-pale slough near center. Undermining continues to the 11 o'clock area measuring 1.1 cm. Small amount of pale yellow-tan drainage. Physician was notified. Resident encouraged to reposition.</p> <p>On 11/27/24, a weekly skin assessment measurements 2 cm by 1 cm by 1.4 cm with 50% granulation tissue and 50% pale yellow-white slough. Undermining noted slightly at edges of wound longest at 12 o'clock with 1 cm. Physician was notified.</p> <p>On 11/27/24, new treatment change to dry blue foam dressing to fit wound bed.</p> <p>On 12/3/24, a late entry for 10/31/24, a skin problem note documented measurements of 1.5 cm by 1 cm by 1 cm with 80% slough.</p> <p>On 12/05/24, a weekly skin assessment measurements 1.9 cm by 1.1 cm by 1.1 cm with pale yellow slough marbled throughout wound. Undermining continues at approximately 12 o'clock with approximately 1.1 cm in length. Small-moderate amount of serous drainage. No odor. Physician was notified. Resident educated to reposition and off-loading.</p> <p>On 12/11/24, a weekly skin assessment measurements 1.9 cm by 1.1 cm by 1.0 cm with light amount of pale white-yellow slough marbled throughout wound bed. Undermining remains at 12 o'clock with approximately 1 cm in length. Small-moderate amount of serous drainage. Physician was notified. Resident encouraged to rest and reposition.</p> <p>The facility did not complete a weekly skin assessment on 12/18/24.</p> <p>On 12/27/24, a weekly skin assessment measurements 1.8 cm by 1.1 cm by 0.7 cm with pale yellow slough marbled throughout. Undermining remains at 12 o'clock area at approximately 1.5 cm in length. Moderate amount of light tan serous drainage. Resident encouraged to reposition.</p> <p>On 12/31/24, a new order for Acetaminophen 650 mg daily prn for pain. This order was discontinued on 02/11/25.</p> <p>On 01/03/25, a weekly skin assessment measurements 1.9 cm by 1.1 cm by 2.1 cm with 75% slough that is pale yellow to shades of green to area at 9 o'clock with tan-brown color. Peri wound is noted to be reddened and inflamed. Resident states area is sore. A foul odor is noted. Undermining approximately 1.5 cm noted at 12 o'clock. Message left for provider.</p> <p>Of note, the PI is showing signs of infection and increased undermining, no new interventions were added to the care plan.</p> <p>On 01/03/25, new order for antibiotic Keflex 500 mg daily for 7 days for wound infection. No culture of the wound was obtained.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525624	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/25/2025
NAME OF PROVIDER OR SUPPLIER Grand View Care Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 620 Grandview Ave Blair, WI 54616	
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 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 01/03/25, a new treatment order. Remove old dressing to coccyx area. Cleanse wound with wound cleanser, wound should be thoroughly flushed, removing foreign material and dead tissue. After soaking 4x4 gauze in 20-30 ml Dakins solution, squeeze excess solution from gauze so that it is not dripping, gently pack into all wound bed area. Ensure Dakins soaked gauze is not touching any healthy tissue, only wound tissue. Cover wound area with absorbent dressing, ensuring all wound pockets are crevices are covered. Apply silicone tape to dressing edges to prevent stool from undermining dressing bid AM and PM.</p> <p>On 01/03/25, Nurse Practitioner placed a wound consult order.</p> <p>On 01/09/25, a late entry for 01/08/25 weekly wound assessment. Measurements 2.2 cm by 1.1 cm by 1.5 cm. Wound bed noted to be more red vs slough. No odor today. Undermining ranging in varying lengths from 9 o'clock to 1 o'clock, with longest depth at 1.5 cm. Treatment of Dakins wet to dry dressing BID. Resident stated area is tender. Physician notified. Resident encouraged to offload pressure from site.</p> <p>On 01/09/25, a new order Tramadol HCL 50 mg stat for pain going to wound clinic for wound, having pain in wound.</p> <p>On 01/09/25, a wound center new patient progress note documented in part: She reports that she does have pain around the coccyx area where the wound is. She reports that she has significant musculoskeletal pain, and that lying on her right side is generally more uncomfortable than lying on the left side. She spends most of the day in a recliner, including napping at times. Impression: Pressure Ulcer - Stage IV Deep, but clean wound to fascia overlying sacrum. No exposed, rough bone. Wound likely consequence from prolonged time up in recliner, limited mobility and pain with osteoarthritis.</p> <p>On the MDS, dated [DATE], a significant change assessment, R1 had no behaviors of rejections of cares provided by staff. R1 is dependent on staff assistance for bed mobility. R1 requires maximum assistance from staff for transfers. MDS documented R1 is at risk for PI and has a non-healed stage 4 PI.</p> <p>The facility did not complete a weekly wound assessment on 01/16/25.</p> <p>On 01/17/25, new treatment order. Remove old dressing to coccyx area. Cleanse wound with wound cleanser, wound should be thoroughly flushed, removing foreign material and dead tissue. Loosely pack wound with calcium alginate Silver and cover daily AM.</p> <p>On 01/25/25, a weekly wound assessment measurements 2.0 cm by 1.1 cm by 1.5 cm with some white to yellow slough at the base of the wound. No odor noted. Undermining from 9 o'clock to 1 o'clock with longest depth of 1.5 cm. Treatment of Calcium alginate with silver. Resident did not complain of pain.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525624	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/25/2025
NAME OF PROVIDER OR SUPPLIER Grand View Care Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 620 Grandview Ave Blair, WI 54616	
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 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 01/31/25, a weekly wound assessment measurements 2 cm by 1.6 cm by 1.5 cm with 10% white-yellow slough to wound base. Undermining continues at 12 o'clock with approximately 3 cm of depth. Note PI has increased in size. Undermining from 9 o'clock to 3 o'clock with varying length with 12 o'clock is the longest. Treatment changed to hydroferra blue foam packed to fit in wound bed. Resident had no c/o pain. Physician notified. Resident encouraged to reposition. Message sent out to staff to educate on importance of changing the dressing when there is breakthrough drainage noted or if the dressing is not sealed/intact at the edges.</p> <p>On 02/05/25, a new treatment order. Remove old dressing to coccyx area. Cleanse wound with wound cleanser, wound should be thoroughly flushed, removing foreign material and dead tissue. Loosely pack wound with blue foam so that it touches wound bed and walls, cover with absorbent dressing daily and prn.</p> <p>On 02/07/25, a weekly wound assessment measurements 2.1 cm by 1.0 cm by 1.3 cm with granulation tissue and no slough noted. Periwound is pink, maceration noted to the 3 o'clock to 5 o'clock area at wound edges. Undermining from 11 o'clock to about 3 o'clock with longest/deepest measurement of approximately 3.2 cm with yellow-tan serous drainage. Note the PI undermining has increased in size. No odor. Physician notified. Resident encouraged to rest, reposition.</p> <p>Of note, the facility does not stage the PI from the time first observed on 8/11/24 through 02/07/25, to determine worsening.</p> <p>On 02/11/25, a new order for Acetaminophen 650 mg daily prn for pain.</p> <p>On 02/11/25 at 11:27 a.m., Surveyor observed R1 lying in bed with a pillow under right side of lower back to buttocks. R1 is not offloaded of the coccyx area.</p> <p>On 02/12/25, a new order for Tramadol HCL 75 mg t.i.d. 6:00 a.m., 12:00 p.m., 6:00 p.m. for pain.</p> <p>On 02/12/25 at 10:52 a.m., Surveyor observed wound care. The wound observed to be a stage 4 with undermining. The wound bed had very minimal slough with the wound bed beefy red.</p> <p>On 02/12/25 at 11:54 a.m., Surveyor interviewed R1 about the wound and repositioning. R1 stated she has pain and asked if she could move. Resident was just transferred to recliner for lunch. R1 stated every 2 hours but she does have pain and would like to be positioned in another position.</p> <p>On 02/12/25 at 2:50 p.m., Surveyor observed R1 in bed with head of bed elevated slightly and had a wedge cushion placed on R1's back right side. The wedge cushion was positioned from mid back to distal buttocks. At 2:53 p.m., Surveyor asked Director of Nursing (DON) B to assess R1's positioning and asked if the coccyx area is offloaded to be able to insert hand between resident and wedge without touching R1. DON B inserted her hand and stated R1 was not off loaded.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525624	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/25/2025
NAME OF PROVIDER OR SUPPLIER Grand View Care Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 620 Grandview Ave Blair, WI 54616	
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 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 02/12/25 at 11:58 a.m., Surveyor interviewed Nurse Practitioner (NP) I asking if the wound was avoidable. NP I indicated in a sense it is avoidable and also unavoidable as the resident does not want to reposition and has been educated and the family also educated numerous times. Surveyor asked if there were any medical indications that would make the resident at risk for further decline in skin and healing. NP I indicated there is no medical issues to cause decline to make it unavoidable. R1 has lost weight per resident wishes as her diet before coming to the facility was very poor and now she is getting a balanced diet.</p> <p>On 02/13/25 at 9:50 a.m., Surveyor interviewed NHA A about the air mattress. NHA A indicated the mattress for R1 is rated up to a stage 3 pressure injury.</p> <p>Of note, the air mattress on R1's bed was appropriate for up to a stage 3 PI. However, the wound clinic staged R1's PI as a stage 4. There is no indication the mattress was changed to provide additional pressure relief.</p> <p>The failure to ensure that nurses and CNAs had the appropriate training and knowledge to prevent and care for pressure injuries created a finding of immediate jeopardy for R1. The immediacy was removed on 02/21/25 when the facility completed the following:</p> <ol style="list-style-type: none"> 1. Full facility skin assessment sweep completed by facility nursing leadership. Wound Care Consultant (Gentell) rounded on 2/14/25 for residents with areas of wound concerns all but one resident who was out for a procedure. Wound Consultant returns Thursday 2/20/25. First wound rounds is Tuesday 2/18/2025 at 10am. 2. Full facility Braden Scale Sweep competed by nursing leadership. 3. Interventions put in place based on Braden scale score. 4. All care plans for residents with any skin concerns reviewed for appropriate interventions and updated. 5. For all pressure injuries identified or current, review each resident's nutrition, appetites, weights, blood sugar, hydration competed by nursing leadership to make sure appropriate interventions are in place for those residents. 6. Inventory of all mattresses and cushions that residents utilize and identify the stages for each. Changes made to these to make sure they are appropriate for the needs of the residents. 7. Get a Alternating Air Mattress ordered that supports up to a Stage IV wound. - Ordered 2/17/2025, ETA 2-3 days. 8. Obtain mattress and cushion information from manufacturer or supplier to make sure they meet the correct needs of the residents. 9. Hydration assessments on residents whom are identified for Pressure Ulcers. 10. Training for RNs and LPNs was initiated on 2/15/2025, to be complete by 02/21/25. <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525624	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/25/2025
NAME OF PROVIDER OR SUPPLIER Grand View Care Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 620 Grandview Ave Blair, WI 54616	
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 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-Admission Checklist and Re-Admission Checklist and implementing a base-line care plan for skin break down interventions based on the Braden Scale.</p> <p>-Wound assessments, staging, types of ulcers, and documentation provided by Nursing Leadership.</p> <p>-Implementation of wound rounds and the responsibilities of the floor nurses related to this, notifications for MD, RN, and POAs.</p> <p>-New pressure ulcer checklist, the expectations of assessment, notifications, and documentation.</p> <p>-Completing Braden Scale assessments correctly. Education on interventions that need to be put in place based off of the Braden Scale Score.</p> <p>11. Training of RN, LPN, and CNAs</p> <p>-On positioning devices, mattresses, and cushion to ensure they know the correct item needed based on residents' pressure ulcer.</p> <p>-Positioning and repositioning. How to do it correctly and appropriate timing of repositioning including documentation of refusals and acceptance.</p> <p>-Intake documentation policy for meal and fluid intakes and snacks.</p> <p>12. Implement weekly Wound Rounds to be completed on Tuesday Mornings at 10am. Team will consist of Wound Nurse, DON, MDS Coordinator, Infection Preventionist, Floor Nurse, and CNA. working with resident as needed. During these rounds wounds will be assessed and measured. Current care plan will be brought with to rounds. Teams will assess that all listed interventions are in place, cushions, mattress, repositioning, no kinked tubing, proper inflation of cushion if needed. After round assessment the nursing leadership team and culinary manager will meet to review the care plan, review all interventions are appropriate and initiate new interventions. Team will also review Braden scales, hydration, appetites, supplements, and current treatment orders for appropriateness and to initiate new interventions. Will also review nursing and CNA documentation for accuracy and that it is completed.</p> <p>Update Admission and Re-admission checklist to clarify the expectations upon admission for the Skin assessment, braden scale, and interventions implemented in the baseline care plan.</p> <p>Implement checklist for nursing to use when a new skin concern; pressure or ulcer area. (Not for skin tears or abrasions). The checklist will have all assessment and interventions that should be considered or put in place when a new area is indicated to make sure that proper assessment and interventions are put in place immediately. The checklist will then be given to DON to review. Checklist will also have examples of interventions that can be put in place.</p> <p>Implement new documentation for meals, fluids, and snacks.</p> <p>Implement provider and resident representative being updated weekly after wound rounds with current wound measurements and wound assessment.</p> <p>Update policy and procedures related to skin, wounds, Braden scales, and repositioning</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525624	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/25/2025
NAME OF PROVIDER OR SUPPLIER Grand View Care Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 620 Grandview Ave Blair, WI 54616	
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 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Monitoring, audits, Quality Assurance and Performance Improvement Plan</p> <p>DON or designee will receive new pressure ulcer checklist to review.</p> <p>Skin Care interventions will be reviewed during wound round assessments and meeting. Skin documentation will be reviewed for accuracy during this meeting and education provided to staff if inaccuracies are noted during monitoring.</p> <p>Audits will be completed to review braden scale assessment, wound documentation, dressing competencies, care plans, and resident repositioning. - Nursing Leadership will conduct audits daily for 2 weeks, weekly for 8 weeks, and monthly for 3 months of residents with pressure injuries.</p> <p>QAPI will review all residents with wounds monthly for 1 year.</p> <p>QA will review all resident with wounds quarterly for 1 year and review/update skin care policies as needed.</p> <p>Facility Assessment will be updated related to any wound resident care requirements.</p> <p>The deficient practice continues at a scope/severity of D (potential for harm/isolated) as evidenced by:</p> <p>Example 2</p> <p>R2 was admitted to the facility on [DATE] with hospice care starting on 08/30/24. R2's diagnoses include dementia with psychotic disturbance, chronic pain syndrome, urinary incontinence, severe protein-calorie malnutrition, cerebral infraction with residual deficits, Alzheimer's disease, anxiety, and major depressive disorder.</p> <p>The MDS, dated [DATE], an admission assessment, documented a BIMS score of 6 out of 15, meaning severe cognitive impairment. R2 has physical and verbal behaviors and rejection of cares. R2 requires maximum assistance of staff for eating, oral care, bed mobility and transfers. R2 is dependent on staff for toileting hygiene, showers, and personal hygiene. R2 has physical impairments to one side of upper and lower extremities. R2 is at risk for PI and has no open PI.</p> <p>On 09/06/24, the facility completed a Braden pressure injury risk assessment with a score of 17, indicating R2 is at mild risk for skin breakdown.</p> <p>Physician orders</p> <p>Orders on 08/29/24 for meal supplement of Ensure vanilla with all meals, acetaminophen 650 mg three times a day for pain, gabapentin 100 mg daily in AM for left hand pain, gabapentin 300 mg daily at bedtime for left hand pain.</p> <p>Orders on 08/31/24 for methadone HCL 15 mg three times a day for chronic pain.</p> <p>Orders on 09/16/24 for lidocaine 4% patch to lower back 12 hours on and 12 hours off.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525624	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/25/2025
NAME OF PROVIDER OR SUPPLIER Grand View Care Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 620 Grandview Ave Blair, WI 54616	
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 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Orders on 10/10/24 an order for Juven a nutritional supplement packet by mouth b.i.d. (twice a day) AM and HS for wound healing.</p> <p>Orders on 12/17/24 Morphine Sulfate 20 mg solution by mouth 1 ml / 20 mg every hour for pain and dyspnea (for end of life).</p> <p>The care plan, revised dated 12/03/24, read, I have the potential to have a skin injury .interventions (pressure relieving mattress with pump, use pillows and wedge to reposition me, encourage resident to adhere to repositing care, plan, providing education on the importance of preventing further skin breakdown, turn and reposition resident at least every 2 hours while in bed - as she allows) (10/04/24 Equagel protector cushion - 2.5 to recliner/wheelchair) (10/14/24 Encourage resident to wear podus boot to left foot while in bed for left heel redness as she allows) (10/25/24 Side to side positioning when in bed as resident allows, educate resident on importance of offloading from coccyx.)</p> <p>On 09/12/24, a skin problem note documented a late entry for 09/11/24. Deep dark red-purple area of tissue noted to left inner buttock, as well as right inner buttock. Left site measure 5 cm x 5 cm. has round edges and is purple like in color at inner most area. Outer area is dark red, neither area blanches upon touch.</p> <p>Right site (right buttock) noted to be dark red in color, does not blanch upon touch and measures 1.5 cm x 1.5 cm. No open areas present at this time. Resident has been noncompliant with repositioning since admission, and likes to sit/lay flat on back/buttocks while in bed. Does have air mattress, will ask hospice to bring their own as well as any repositioning tools . applied Lantiseptic and strict offloading of area encouraged. Provider NP updated, No New Orders. Hospice nurse updated. Floor nurse to update POA. DON updated, as well.</p> <p>The facility did not complete a comprehensive PI assessment.</p> <p>Of note, an air mattress was in place on 09/12/24.</p> <p>NPIAP definition of a Deep Tissue Injury: Persistent non-blanchable deep red, maroon or purple discoloration Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4).</p> <p>Of note, the above skin description on 9/12/24 meets the NPIAP definition for a DTI.</p> <p>The facility did not stage the wound when first noted on 9/12/24.</p> <p>On 09/20/24, a weekly skin assessment: Note this assessment was 2 days late.</p> <p>Left inner buttock measurements 3.5 cm by 0.5 cm, closed scabbed over, no drainage, dark red-purple in color.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525624	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/25/2025
NAME OF PROVIDER OR SUPPLIER Grand View Care Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 620 Grandview Ave Blair, WI 54616	

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 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Lower spine, center above sacral area measurements 1.5 cm by 1.8 cm, closed area is dark pink tissue, non-blanching. Bordered foam for protection to be changed every 3 days.</p> <p>Left upper buttock to coccyx measurements 5 cm by 7 cm, skin is red and non-blanching upon touch.</p> <p>Left of sacrum, redness non-blanching measurements 3.5 cm by 2.5 cm closed.</p> <p>Right of sacrum measurements 5 cm by 4 cm closed and non-blanching.</p> <p>Right of sacrum below large area measurement 2.5 cm by 1.5 cm closed.</p> <p>The open areas above are not staged, bu [TRUNCATED]</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525624	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/25/2025
NAME OF PROVIDER OR SUPPLIER Grand View Care Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 620 Grandview Ave Blair, WI 54616	
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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46694</p> <p>Based on observation, interview, and record review, the facility did not ensure the resident environment remained as free of accidents as possible for 1 of 3 residents (R7) reviewed for accidents.</p> <p>R7 has a history of falls and has had 8 falls since admission. On 01/27/25, the facility failed to ensure that R7's fall interventions were in place resulting in R7 having a fall with injury requiring staples to the head, as well as a skin tear. This is cited at actual harm.</p> <p>Findings:</p> <p>The facility's Fall - Clinical Protocol policy dated 04/03/23 states in part, Assessment and Recognition</p> <p>1. As part of the initial assessment, the physician will help identify individuals with a history of falls and risk factors for subsequent falling.</p> <p>a. Staff will ask the resident and the caregiver or family about a history of falling.</p> <p>b. The staff and physician should document in the medical record a history of one or more recent falls.</p> <p>c. While many falls are isolated individual incidents, a significant proportion occur among a few residents/patients. Those individuals may have a treatable medical disorder or functional disturbance as the underlying cause .</p> <p>Cause Identification: For an individual who has fallen, staff will complete root cause analysis.</p> <p>a. Causes refer to factors that are associated with or that directly result in a fall; for example, a balance problem caused by an old or recent stroke.</p> <p>b. Often, multiple factors in varying degrees contribute to a falling problem .</p> <p>Treatment/Management:</p> <p>1. Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling .</p> <p>2. If underlying causes cannot be readily identified or corrected, staff will try various relevant interventions, based on assessment of the nature or category of falling, until falling reduces or stops or until a reason is identified for its continuation (for example, if the individual continues to try to get up and walk without waiting for assistance).</p> <p>R7 was admitted to the facility on [DATE] with a diagnosis of end-stage Alzheimer's disease and on hospice.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525624	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/25/2025
NAME OF PROVIDER OR SUPPLIER Grand View Care Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 620 Grandview Ave Blair, WI 54616	
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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>R7's most recent minimum data set (MDS) dated [DATE] indicated that R7 did not have a fall in the last month and had five falls in the last 2-6 months. R7 has a Brief Interview for Mental Status (BIMS) of 3 out of 15, indicating severe cognitive impairment. R7 requires setup/cleanup assistance with eating, requires substantial/maximum assistance with oral hygiene, toileting hygiene, upper and lower body dressing, and personal hygiene, and R7 is dependent on staff for putting on and taking off footwear. R7 walks 10, 50, and 150 feet with substantial/maximum assistance of staff. R7 requires partial/moderate assistance with rolling left to right, sit to lying, lying to sitting and sit to stand. R7 requires substantial/maximum assistance with toileting and chair/bed-to-chair transfers. R7 is occasionally incontinent of urine and always continent of bowel.</p> <p>Fall Risk Assessment for R7 completed on 06/05/24 shows a score of 18 indicating R7 was at risk for falling. Assessment indicates R7 has decreased awareness, poor recall and judgement for mental factors.</p> <p>Fall Risk Assessment for R7 completed on 09/05/24 shows a score of 25 indicating R7 was at a risk for falls. Assessment indicates R7 has decreased awareness, poor recall and judgment for mental factors.</p> <p>Fall Risk Assessment completed on 11/20/24 shows a score of 17 indicating R7 was at a risk for falls. Assessment indicates R7 has decreased awareness, poor recall and judgement for mental factors.</p> <p>R7's fall care plan was initiated on 06/04/24. Interventions included, I need my aides to make sure my important items are within my reach, give me non-skid footwear, so I don't slip, make sure my hearing aids are in and are working, remind me to wear my glasses, encourage me to use assistance, report signs that I am in pain to my nurse.</p> <p>Falls investigation are as follows, in part:</p> <p>On 06/09/24 at 8:58 PM, witnessed fall while transferring resident. Injury of skin tear to the left elbow. Immediate intervention put into place: Education provided to staff regarding transfers and making sure shoes are tied prior to standing resident.</p> <p>On 06/19/24 at 7:55 PM, unwitnessed fall. Skin tear to left elbow reopened. Immediate interventions put into place: Offer recliner after supper until bedtime.</p> <p>On 07/17/24 at 4:25 PM, witnessed fall. Has complaints of right elbow and right hip pain. Immediate intervention put into place: Reinforce to resident following each transfer that resident should not attempt to walk alone without walker.</p> <p>On 08/25/24 at 11:00 PM, unwitnessed fall. Hematoma to posterior head. Immediate interventions put into place: Remind resident to call for help before getting up. Place signs around room and on walker to call for help before getting up.</p> <p>On 09/16/24 at 1:15 PM, unwitnessed fall. Abrasion to the back of the head. Immediate interventions put into place: Bell placed on walker to alert staff when resident is moving.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525624	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/25/2025
NAME OF PROVIDER OR SUPPLIER Grand View Care Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 620 Grandview Ave Blair, WI 54616	
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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/08/24 at 7:00 AM, witnessed fall. Laceration to left elbow and a red bump the size of a quarter to middle back of the head. Immediate interventions put into place: Hospice to adjust medication times to not wake resident for medications (per daughter).</p> <p>On 12/11/24 at 5:53 PM, unwitnessed fall. Irregular shaped, dark blue/purple bruising to right temple area. Immediate intervention put into place: When up in the circle she is in her wheelchair.</p> <p>On 01/27/25 at 7:25 AM, unwitnessed fall. Laceration/hematoma to right side of head. Educated staff on ensuring resident is wearing gripper socks at times when she is not wearing shoes.</p> <p>Of note: R7's fall care plan initiated on 06/04/24 indicates R7 is to have non-skid footwear. This was again listed as an intervention in all care plan revisions and following the fall on 01/27/25 when R7 was noted to not have the intervention in place at time of the fall.</p> <p>On 01/27/25, incident report findings:</p> <p>Date 01/27/25, Time 7:25 AM, Incident type: fall-unwitnessed leading to laceration.</p> <p>Location: Nurses station</p> <p>Activity at the time: Resident was seen by writer sleeping in the recliner chair 5 minutes prior to the fall.</p> <p>Equipment involved: recliner chair.</p> <p>Possible cause: Resident possibly tried to get up without assistance (she does this very often). Resident was barefoot as well.</p> <p>Mental state: normal for resident.</p> <p>Injury: laceration/hematoma to right side of head (W [sic] large amount of blood), a cut to left hand, and skin tear/bruising to R.</p> <p>First aid: immediately applied, transferred to emergency room .</p> <p>On 01/27/25, emergency room record findings:</p> <p>Physical examination:</p> <p>.HEENT: head is normocephalic, she has an inch and a half laceration to the mid scalp that is approximately 4 mm deep .</p> <p>Medical Decision Making:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525624	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/25/2025
NAME OF PROVIDER OR SUPPLIER Grand View Care Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 620 Grandview Ave Blair, WI 54616	
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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>.emergency room Evaluation: Upon arrival to the ER patient is hemodynamically stable. Her skin tear and scalp lacerations were cleansed with copious amounts of chlorhexidine and saline. For her skin tear, some bacitracin applied and a sterile clean dressing place. Her scalp laceration was stapled. Sick [sic] staples were placed, patient tolerated procedure well. After stapling, good hemostasis obtained. Some bacitracin was then applied. I did obtain a head CT and cervical CT which were both negative. Cervical collar was then removed, and her neck cleared.</p> <p>Impression: The primary encounter diagnosis was accidental fall, initial encounter. A diagnosis of laceration of scalp, initial encounter was also pertinent to this visit.</p> <p>Of note: R7 did not have care planned intervention in place, non-skid footwear, not on at time of the fall on 01/27/25 that resulted in a head laceration requiring six staples.</p> <p>On 02/12/25 at 11:21 AM, Surveyor interviewed Director of Nursing (DON) B. Surveyor informed DON B that the root cause for the fall dated 01/27/25 was the resident tried to get up without assistance and resident was barefoot as well. Surveyor asked DON B what the facility did after this fall. DON B replied, The staff were reeducated on the use of gripper socks when the resident was not wearing shoes.</p> <p>On 02/12/25 at 2:00 PM, Surveyor asked DON B for a copy of any education provided to staff following fall investigation from 1/27/25. DON B replied, We had a 'Fall Huddle' and this was verbal education given based on the appropriate intervention. Surveyor asked DON B, Do you believe that staff education should have been given and documented instead of a 'Fall Huddle'? DON B replied, No, in this case I think that the last 24 hours of staff that worked with this resident should have been talked to to make sure that they were aware of what went wrong.</p> <p>On 02/12/25 at 12:50 PM, Surveyor asked Certified Nursing Assistant (CNA) E, If this resident's care plan was to make sure the resident had on non-skid footwear and [R7] was barefoot when the fall took place, was the care plan followed? CNA E replied, No it wasn't.</p> <p>On 02/12/25 at 12:51 PM, Surveyor asked CNA D, If this resident's care plan was to make sure the resident had on non-skid footwear and [R7] was barefoot when the fall took place, was the care plan followed? CNA D replied, No it wasn't.</p> <p>On 02/12/25 at 12:52 PM, Surveyor asked Registered Nurse (RN) C, If this resident's care plan was to make sure the resident had on non-skid footwear and [R7] was barefoot when the fall took place, was the care plan followed? RN C replied, The staff followed the care plan, but she most likely took off her nonskid footwear.</p> <p>On 02/12/25 at 12:59 PM, Surveyor asked DON B, If this resident's care plan was to make sure the resident had on non-skid footwear and [R7] was barefoot when the fall took place, was the care plan followed? DON B replied, No, at that time we were not following the care plan.</p> <p>The facility failed to ensure that R7's care planned interventions were in place to prevent falls resulting in R7 having a fall with scalp laceration that required staples.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525624	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/25/2025
NAME OF PROVIDER OR SUPPLIER Grand View Care Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 620 Grandview Ave Blair, WI 54616	

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 0895</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Have a Compliance and Ethics Program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41945</p> <p>Based on interview and record review, the facility did not develop a compliance and ethics program that has been reasonably designed, implemented, and enforced so that it is likely to be effective in preventing and detecting criminal, civil, and administrative violations under the Act and promote quality of care. This has the potential to affect all 43 residents.</p> <p>Findings include:</p> <p>On 02/25/25, Surveyor reviewed the facility assessment dated [DATE] and revised on 02/20/24. The facility assessment does not include ethics and compliance training.</p> <p>On 02/25/25 at 2:00 p.m., Surveyor interviewed Nursing Home Administrator (NHA) A and asked if the facility had an ethics and compliance program.</p> <p>NHA A stated she knew the facility needed a program, but due to other issues/priorities that arose, this was put aside and never implemented.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525624	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/25/2025
NAME OF PROVIDER OR SUPPLIER Grand View Care Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 620 Grandview Ave Blair, WI 54616	
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 0944</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program.</p> <p>49353</p> <p>Based on interview and record review, the facility did not ensure staff received Quality Assurance Performance Improvement (QAPI) program training. This practice had the potential to affect all 43 residents in the facility.</p> <p>The facility did not provide any staff with required training on the facility's QAPI plan.</p> <p>This is evidenced by:</p> <p>The facility's Quality Assurance & Performance Improvement Plan, dated 01/2024, states in part:</p> <p>Staff Training and Orientation</p> <p>In order for caregivers to become and remain proficient with quality improvement tools and techniques, QAPI principles and staff responsibilities related to QAPI, and ongoing quality improvement will also be included in orientation for all new employees. In order to become and remain proficient with quality improvement tools and techniques all staff will participate in ongoing annual QAPI training .</p> <p>On 02/25/25, Surveyor reviewed the facility's new orientation and annual education completed with staff. Surveyor observed no training identified as QAPI education.</p> <p>On 02/25/25 at 1:54 AM, Surveyor interviewed Nursing Home Administrator (NHA) A regarding QAPI training. NHA A stated the facility currently did not have QAPI education included in new orientation or annual education for all employees. NHA A stated this was identified as a missing piece of education needed for all staff and would be working on creating a new orientation and annual QAPI training program.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525624	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/25/2025
NAME OF PROVIDER OR SUPPLIER Grand View Care Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 620 Grandview Ave Blair, WI 54616	

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 0946</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Provide training in compliance and ethics.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41945</p> <p>Based on interview and record review, the facility did not set forth an effective way to communicate the program's standards, policies, and procedures through a training program or in another practical manner which explains the requirements under the program. This has the potential to affect all 43 residents.</p> <p>Findings include:</p> <p>On 02/25/25, Surveyor reviewed the facility assessment dated [DATE] and revised on 02/20/24. The facility assessment does not include ethics and compliance training.</p> <p>On 02/25/25, Surveyor reviewed three Certified Nursing Assistant (CNA) training records, and two licensed staff training records. CNA M, CNA N, CNA O, Registered Nurse (RN) H, Licensed Practical Nurse (LPN) K did not receive ethics and compliance training.</p> <p>On 02/25/25 at 2:00 p.m., Surveyor interviewed Nursing Home Administrator (NHA) A and asked if the facility had an ethics and compliance program and how they effectively communicate the program's standards, policies, and procedures through a training program NHA A stated she knew the facility needed a program, but due to other issues/priorities that arose, this was put aside. NHA A acknowledged there is no training.</p>