STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525643	A. Building B. Wing	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant View Nursing Home	N3150 WI-81 Monroe, WI 53566

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33166 Based on interview and record review, the facility failed to ensure residents receive the care and treatment in accordance with professional standards of practice and the comprehensive person-centered care plan for 2 of 2 residents reviewed (R8 and R4). R8 did not have neurological checks completed after a fall per facility protocol. R4 was admitted with orders to weigh daily and update the Physician with a weight increase or decrease by 3 lbs. (pounds) in a day or 5 lbs. in a week. R4's weights were not completed daily, and the physician was not always informed when weights fell outside the given parameters. This is evidenced by: The facility has an Unwitnessed Fall Checklist, undated, which state in part; if resident is unable to tell you if they hit their head, assume they did and do neuro (Neurological) checks with vital signs. Neuro checks are to be completed in PCC (Point Click Care/Electronic Health Record) under the assessment tab. Vital signs/Neuro Checks at time of fall and fifteen minutes after fall, 1 hour after fall and each shift for 24 hours after fall for 72 hours. Facility policy titled, Weight and Measuring the Resident, last reviewed, 3/2011, states in part . Purpose: The purposes of this procedure are to determine the resident's weight and height, to provide a baseline and ongoing record of the resident's body weight as an indicator of the nutritional status and medical condition of the resident, and to provide a baseline height in order to determine the ideal weight of the resident. Preparation: 5. When weighing the resident, the following guidelines will promote accurate weight assessment across time: a. If practical, weigh at the same time of day each day. b. If the resident's condition permits, use the same scale for weighing the resident each time. Interact Version 4.5 Tool for Change in Condition: When to report to the MD/NP/PA (Medical Doctor/Nurse Practitioner/Physician Assistant), states in part . Immediate Notification: Any symptom, sign or apparent discomfort that is: Acute or Sudden in onset, and: A Marked Change (i.e., more severe) in relation to usual symptoms and signs, or Unrelieved by measures already prescribed. Weight Loss: Report Immediately: 5% (percent) or more within 30 days. Weight Gain: > (greater than) 5 lbs (pounds) in one week in resident with CHF (congestive heart failure), chronic renal failure, other volume overload state. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Example 1 R8 was admitted to the facility on [DATE] with diagnoses that include Alzheimer's Dementia, Aphasia, Seizure Disorder and Weight Loss. R8's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/16/24 indicated R8 had severe cognitive impairment and R8 was dependent on staff for transfers. R8's Activities for Daily Living (ADL) care plan, states in part; Goal: I will maintain current level of function in dependence through 8/18/24. Interventions: Transfer: I use a medium (Beige colored) EZ Lift Hoyer sling. Progress Note dated 7/20/24 at 6:59 PM states in part; Taken to room after supper resident in wheelchair when CNA (Certified Nursing Assistant) went in to room found resident on the floor on right side. Reddened area on right cheek and small bruise forming on left hand by her middle finger. Unwitnessed fall neuros (Neurological Checks) started. R8 has the following neurological checks noted: 7/20/24 at 7:18 PM pupils were equal and reactive to light indicating neurological functions intact. 7/20/24 at 7:35 PM pupils were equal and reactive to light indicating neurological functions intact. Of note, the next set of Neuro checks should have been around 8:35 PM. 7/20/24 at 9:43 PM pupils were equal and reactive to light indicating neurological functions intact. 7/21/24 at 6:30 AM pupils were equal and reactive to light indicating neurological functions intact. 7/21/24 at 10:54 pupils were equal and reactive to light indicating neurological functions intact. There were no further neurological checks. R8 should have had neurological checks on 7/22/24 and again on 7/23/24 per facility protocol. On 9/17/24 at 9:00 AM, Surveyor interviewed DON B (Director of Nursing) regarding R8's neuros checks and facility protocol. DON B stated she would review the record and get back to Surveyor. On 9/17/24 at 10:10 AM, DON B stated there were no further neuro checks for R8 and the facility did not follow their protocol. 39713 Example 2 (continued on next page)

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	525643	A. Building B. Wing	09/17/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R4 was admitted to the facility on [DATE], with diagnoses, including, but not limited to, abnormal weight loss, chronic diastolic (congestive) heart failure, COPD (chronic obstructive pulmonary disease), hypertensive heart disease with heart failure, and chronic pain. R4's most recent quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 9/10/24 indicates R4 is cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15 out of 15. R4's care plan states in part . Focus: I have Congestive Heart Failure Interventions: Weight daily. Date Initiated: 7/10/24. Focus: I have coronary artery disease (CAD) r/t (related to) lifestyle choices, hx. (history) of smoking. Interventions: Weight daily. Date Initiated: 6/06/24. Focus: I have potential fluid volume overload r/t CHF. Interventions: Weight daily. Notify MD (Medical Doctor), RD (Registered Dietician) of sudden wt. (weight) changes. R4's physician orders, states in part . Weigh daily one time a day for CHF (Congestive Heart Failure), CHF patient, notify provider if weight gain > (greater) 3 lbs. (pounds) in one day, >5 lbs. in one week, or increased leg pain/swelling or SOB (Shortness of Breath); AND notify monthly if weight loss/gain is >5% (percent) in one month, >7% in three months, >10% in 6 months. R4's weights are documented from 7/6/24 until present as follows: 7/06/24 - 251.8 lbs. 7/09/24 - 248.6 lbs. 7/13/24 - 249.6 lbs. 7/21/24 - 241.6 lbs. 7/24/24 - 238.6 lbs. 7/26/24 - 237.6 lbs. 8/12/24 - 246.2 lbs. (increase of 8.6 lbs., NP (Nurse Practitioner) updated 8/13/24 of weight increase) (continued on next page)

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	525643	A. Building B. Wing	09/17/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8/19/24 - 243.4 lbs. 8/22/24 - 237.1 lbs. 8/24/24 - 237.5 lbs. 8/26/24 - 246.2 lbs. (increase of 8.7 lbs., NP updated on weight increase) 8/29/24 - 251.6 lbs. (increase of 5.4 lbs., NP updated on weight increase) 9/02/24 - 248 lbs. 9/07/24 - 248.3 lbs. 9/10/24 - 257.6 lbs. (increase of 9.3 lbs., NP updated on weight increase) 9/11/24 - 257.6 lbs. 9/12/24 - 255.8 lbs. 9/13/24 - 255.2 lbs. 9/16/24 - 257.4 lbs. Note: Weights were not obtained as ordered on the following dates, 7/04, 7/08, 7/10, 7/11, 7/12, 7/14, 7/15, 7/16, 7/17, 7/18, 7/19, 7/20, 7/22, 7/23, 7/25, 7/27, 7/28, 7/29, 7/30, 7/31, 8/01, 8/02, 8/03, 8/04, 8/05, 8/06, 8/07, 8/08, 8/09, 8/10, 8/11, 8/13, 8/14, 8/15, 8/16, 8/17, 8/18, 8/21, 8/23, 8/25, 8/27, 8/28, 8/30, 8/31, 9/01, 9/03, 9/04, 9/05, 9/06, 9/08, 9/09, 9/14, and 9/15. On 9/16/24 at 3:05 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B what standard of practice the facility uses. DON B stated, AMDA (The American Medical Directors Association) guidelines. Surveyor asked DON B the facility procedure for obtaining weights. A weight should be obtained weekly on admission for 4 weeks, then monthly. If there is a physician's order for something different, that should be followed weights should be done daily if they are ordered that way. If a resident refuses the staff will try again later or wait until the next day. Staff should be documenting any resident's refusal to have weight obtained. Refusals should also be reported to the nurse. CNA's (Certified Nursing Assistants) put weights in the computer system. Surveyor asked DON B what happens if weight is off or is significantly higher or lower. The computer charting system will trigger the nurse if weight is off and the floor nurses should be reviewing daily weights. On 9/16/24 at 3:45 PM, Surveyor interviewed CNA L and CNA O. Surveyor asked CNA L and CNA O about the facility process for obtaining weights. CNA L stated resident weights are obtained on bath days. The nurse will let us know any weights and vital signs that need to be taken. Then we either write them down and put them in the computer or give them to the nurse. CNA O indicated she would follow the same process as what CNA L had stated. (continued on next page)

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	525643	A. Building B. Wing	09/17/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/17/24 at 6:30 AM, Surveyor interviewed CNA M. Surveyor asked CNA M the facility process for obtaining resident weights. CNA M stated, the nurse tells us who is a weight that day. We obtain the weight then give the weight to the nurse and chart it in the medical record. Surveyor asked CNA M if there is anything that triggers to let them know that the weight is off. CNA M stated, it does not trigger us that I have noticed in the CNA charting. The nurse should look and see if there is an issue with the weight that was obtained. Surveyor asked CNA M how they obtain a re-weight. CNA M stated if a re-weight is needed the nurse lets us know. On 9/17/24 at 6:35 AM, Surveyor interviewed RN N (Registered Nurse). Surveyor asked RN N facility process for obtaining weights. RN N stated, we do our weights weekly on admit for 1 month then monthly, if a resident has CHF, they are daily weights. If a resident gains >3 lbs. in a day or >5 lbs. in a week we would need to update the physician. Staff would also update the physician if gain of 5% in a month, 7% in 3 months, and/or 10% in 6 months. RN N stated the CNA's would update the nurse if R4 or another resident is still refusing. R4 refuses a lot due to pain. Surveyor asked RN N if she updates the physician when R4 refuses. RN N stated, I don't update every time R4 refuses. R4 is doing better now and back in therapy. The facility failed to obtain daily weights for R4 as ordered and update the physician when daily weights could not be obtained.

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	525643	A. Building B. Wing	09/17/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 33166 UNCORRECTED AT VERIFICATION VISIT. See SOD for Event ID #MK7V11 Based on observation, interview, and record review, the facility did not ensure adequate supervision and safety to prevent accidents for 4 of 4 residents (R8, R10, R4, and R7) reviewed for falls/accidents and 4 of 4 residents (R1, R6, R2, and R5) reviewed for resident to resident/supervision. R8 required a two-person transfer with a full body lift, a staff member completed the transfer independently and R8 fell out of the lift. Staff did not follow R10's care plan when they transferred R10 to the restroom. Staff did not have foot pedals on R10's chair and Surveyor observed staff pushing R10 down the hall with his left leg dragging under the wheelchair seat. R7 was observed self transferring without gripper socks. R4 was transferred with the incorrect sling. R1 has the potential to be physically aggressive related to dementia and has a recent history of having resident to resident interactions at the facility. R1's care plan has an intervention that R1 is to be monitored every shift. R1 was observed in a common area with another resident and in an activity with other residents with no staff within line of sight or in the immediate area. R2 has the potential to be physically and or verbally aggressive related to dementia. R2's care plan has an intervention that R2 is to be monitored. R2 was observed in a common area with other residents with no staff within line of sight or in the immediate area. R6 has the potential to be physically aggressive related to dementia with a history of harm to others. R6 was observed in a hallway with other residents with no staff within line of sight or in the immediate area. R5 was not monitored per plan of care and was involved in a resident-to-resident incident with R1. This is evidenced by: (continued on next page)

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	525643	A. Building B. Wing	09/17/2024

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Facility Falls-Clinical Protocol Policy, dated 2001 with last revision date of [DATE], states in part: As part of the initial assessment, the physician will help identify individuals with a history of falls and risk factors for subsequent falling .The staff will document risk factors for falling in the resident's record and discuss the resident's fall risk .For an individual who has fallen, staff will attempt to define possible cause within 24 hours of the fall .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 .If underlying causes cannot be readily identified or corrected, staff will try various relevant interventions .The staff and physician will monitor and document the individual's response to interventions intended to reduce falling .If the individual continues to fall, the staff and physician will re-evaluate the situation and consider other possible reasons for the resident's falling and will re-evaluate the continued relevance of current interventions . The facility policy titled, Lifting Machine, Using a Mechanical, last revised, [DATE], states in part . Purpose: The purpose of this procedure is to establish the general principles of safe lifting using a mechanical lifting device. General Guidelines: 1. At least two (2) nursing assistants are needed to safely move a resident with a mechanical lift. Steps in the Procedure: 2. Measure the resident for proper sling size and purpose, according to manufacturer's instructions. 13. Lift the resident 2 inches from the surface to check the stability of the attachments, the fit of the sling and the weight distribution. Facility document titled, EZ Way Sling Sizing Chart, states in part . Sling Color Coding System: Gray, Small; Beige, Medium; Burgundy, Large; Green, XL (extra-large). Sling Size and Weight of Patient: Small, , d+[DATE] lbs (pounds); Medium, ,d+[DATE] lbs; Large, ,d+[DATE] lbs, XL, ,d+[DATE] lbs. Example 1: R8 was admitted to the facility on [DATE] with diagnoses that include Alzheimer's Dementia, Aphasia, Seizure Disorder, and Weight Loss. R8 expired on [DATE]. R8's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] indicated R8 had severe cognitive impairment and R8 was dependent on staff for transfers. R8's Activities for Daily Living (ADL) care plan states in part; Goal: I will maintain current level of function in dependence through [DATE]. Interventions: Transfer: I use a medium (Beige colored) EZ Lift Hoyer sling. Progress Note dated [DATE] at 6:59 PM, states in part; Taken to room after supper resident in wheelchair when CNA (Certified Nursing Assistant) went in to room found resident on the floor on right side. Reddened area on right cheek and small bruise forming on left hand by her middle finger. Unwitnessed fall neuros (neurological checks) started. The FRI (Facility Reported Incident) states in part; found on floor at 6:59 PM. Given (resident name) R8 would not be able to move without assistance, an investigation was initiated to determine if misconduct occurred. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A statement from CNA E indicated that she went in to put R8 to bed at 6:45 PM and found R8 on the floor. CNA E was interviewed again and reported that she was walking by R8's room on her way to do something else and she saw R8 on the floor. A statement from CNA F was told by CNA E that she thought she set up the Hoyer wrong and she made R8 fall but didn't know and then walked in and found R8 on the floor and was scared it was her fault. A statement from LPN G (Licensed Practical Nurse) resident was in her room after supper. Resident was in her w/c (wheelchair) when CNA went into the room, she found the resident on the floor on her right side. Reenactment of event: (Resident name) R8 is in a modified Broda chair with armrest. R8 lacks the ability to move her body in such a way that she would have been able to fall out of the chair on her own. The reports indicate that R8 was seen on her right side, and the chair would have been blocking the view of her being on the floor if she had fallen out of it. The chair had to be pulled away from view. The Hoyer lift and sling were inspected for rips or malfunction, and none were found. Multiple versions of how the fall occurred were reenacted to recreate how she would have ended up on her right side. All scenarios were ruled out but improper use of the sling hooks. Any other possibility would have resulted in R8 being on her back or the error being too obvious during the slow ascent from the chair. Conclusion: CNA E did not follow facility policy and attempted to transfer R8 without the required second person. CNA E did not properly hook R8 up with the sling when transferring her. R8 fell out of the Hoyer lift sling as a result of CNA E not following facility policy. On [DATE], CNA E's employment was terminated. On [DATE] at 2:40 PM, Surveyor interviewed CNA F regarding R8's fall on [DATE]. CNA F stated she was not working the night of the fall however CNA E told her, a few days after the incident, that she thought she put the Hoyer sling under R8 wrong, and she thought it was her fault that R8 fell . On [DATE] at 2:50 PM, Surveyor interviewed LPN G regarding R8's fall. LPN G stated she was the nurse on the floor that night. LPN G stated there is no way R8 fell out of the chair she had to have fallen from the Hoyer. LPN G stated when she entered the room R8 was lying on her right side with her head facing the window and her legs were toward the bed. The chair was facing the closet on the right side of the room and the lift was pushed into the bathroom with the lift legs facing toward the door. LPN G stated it would be impossible for R8 to have fallen from the chair and be in the position she was found. LPN G stated the sling was all bunched up and, in the chair, and just looked off. LPN G stated it was my conclusion CNA E transferred R8 by herself and R8 fell from the Hoyer. LPN G stated CNA E never admitted to this. Surveyor attempted to contact CNA E; however, CNA E did not return the call. (continued on next page)

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	525643	A. Building B. Wing	09/17/2024

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 9:00 AM, Surveyor interviewed DON B (Director of Nursing) regarding R8's fall. DON B stated R8 was found on the floor and based on the investigation it was concluded CNA E transferred R8 by herself and did not hook up the Hoyer sling correctly causing the fall. DON B stated the conclusion was made based on the position of R8 on the floor. We could not get CNA E to admit to it, but it is believed this was the case. Surveyor asked DON B if CNA E followed R8's care plan, DON B stated No, it would be expected staff follow the care plan and residents should be transferred with two staff when using a Hoyer lift. On [DATE], the facility did complete education on using a Hoyer lift which states in part; 2 staff members must be present. The second person is there to prevent serious injury to the resident. Although the facility started the education, only a small number of staff received this training. Example 2: R10 was admitted to the facility on [DATE] with diagnoses that include Parkinson's with dyskinesia (involuntary movements) and repeated falls. R10's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] indicated R10 has a Brief Interview of Mental Status (BIMS) score of 3 indicating R10 has severe cognitive impairment. Section GG indicates R10 requires substantial assistance with sit to stand, personal hygiene, toilet transfer, and toilet hygiene. R10's Activities of Daily Living (ADL) care plan states in part; I will maintain current level of function through the review date of [DATE]; Interventions: Date initiated: [DATE] and revised [DATE] Transporting: I need to have foot pedals applied when transporting me in my w/c, but I like to self-propel intermittently on the unit. Date Initiated: [DATE] Transfer: I am able to transfer with help of 1 person, gait belt and U-Step walker if allow. I frequently transfer by myself, keep my U-step walker and or wheelchair within hands reach. Tell me to give you a hug and I will help with transfers. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 1:05 PM, Surveyor observed R10 in the dining room, R10 was had his head bent down and appeared to be sleeping in his wheelchair. CNA J (Certified Nursing Assistant) approached R10 and told R10 she was going to take him to his room. CNA J began to transport R10 to his room in his wheelchair without the use of his foot pedals. Surveyor observed R10's left foot dragging under the seat of the wheelchair which was pitching R10 forward in his chair. Surveyor stopped CNA J and pointed out R10's left foot. CNA J stated, come on (resident name) R10 pick up your feet, CNA J moved R10's foot in front of the chair. CNA J continued transporting R10 to his room and once again R10's foot started to drag under the wheelchair seat pitching R10 forward. Surveyor stopped CNA J and pointed out R10's foot. CNA J again stated to R10 to pick up his feet. At no time during the transport from the dining room to R10's room did CNA J stop and get R10's footrest. CNA J pushed R10 in to the bathroom and locked the brakes to the wheelchair. R10 continued to have his head hung down and appeared sleepy. Surveyor observed a gait belt hanging on the bathroom door. CNA K entered the room to assist CNA J with transferring R10 to the toilet R10 became resistive to the transfer and CNA J stated to R10, You know (resident name) if you would assist us, it would not be so hard. CNA J and CNA K lifted R10 under his arms and transferred R10 to the toilet. It should be noted R10's care plan indicates R10 should be transferred with a gait belt and his U-step walker; neither CNA placed a gait belt on R10. Once R10 was standing, R10 was having difficulty sitting and CNA J began using her arms and body weight to push R10 into a seated position on the toilet, R10 continued to resist this attempt placing R10 at greater risk for a fall. Once R10 was seated, CNA K exited the room. When R10 was finished using the restroom CNA J asked R10 to stand and R10 was resistive. CNA J stated to R10, I am going to get the lift, and stated to R10 to quit being so stubborn are you going to sit here all day? CNA I entered R10's room and saw CNA J struggling to transfer R10. CNA I stated let me show you a trick that always works for R10. CNA I got down to R10's level and stated (resident name) can you give me a hug. CNA I reached out her hands to R10 and R10 grabbed her hands began to stand and gave CNA I a hug allowing CNA J to provide personal care and clothing adjustments. CNA I sat R10 into his chair and stated, let's get your foot pedals so we can get you to the recliner safely. Surveyor observed a plastic card just inside the doorway with symbols and text indicating R10 is to transfer with a gait belt, U-step walker, and wheelchair to follow. On [DATE] at 1:20 PM, Surveyor interviewed CNA I regarding transfers for R10. CNA I stated she has found asking R10 to give her a hug is the most effective. Surveyor asked R10 should R10 have a gait belt on with transfers and CNA I stated yes we should have had a gait belt. Surveyor asked about the symbol and text card in R10's room CNA J stated that is an at -a - glance on how the resident (R10) transfers. CNA I stated R10 is not always able to use the walker so using a gait belt and the asking for a hug seems to be the best method. Surveyor asked CNA I if R10 should use the foot rest for transport in the wheelchair and R10 stated yes. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525643	A. Building B. Wing	09/17/2024

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Pleasant View Nursing Home	N3150 WI-81 Monroe, WI 53566

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 1:40 PM, Surveyor interviewed CNA J regarding transfers for R10. Surveyor asked CNA J about transporting R10 from the dining room to R10's room Surveyor asked CNA J if she should have used R10's foot rests; CNA J stated yes. Surveyor asked CNA J about the observation of transferring R10 to the toilet and assisting R10 to sit on the toilet. Surveyor asked CNA J how she knows how to transfer a resident. CNA J stated there are cards in the room and the resident's care plan. Surveyor asked CNA J does R10's care plan state to use a gait belt. CNA J stated yes. Surveyor asked CNA J if she used a gait belt and CNA J stated no. Surveyor asked CNA J about assisting R10 to sit on the toilet; Surveyor asked CNA J if pushing on R10 to sit could increase R10's risk of falling CNA J stated yes, R10 was not cooperative today. Surveyor asked if R10's care plan states to use foot pedals for transportation should foot pedals be used when transporting R10? CNA J stated yes and I did not use them. On [DATE] at 9:00 AM, Surveyor interviewed DON B (Director of Nursing) regarding R10's transfers and fall interventions. Surveyor asked DON B if R10 has a care planned intervention and appears sleepy should staff utilize foot rest to transport R10. DON B stated, yes. Surveyor asked DON B if a care plan intervention is to use a gait belt would you expect staff to use a gait belt and DON B stated yes. Surveyor asked DON B about staff assisting R10 to sit on the toilet and DON B stated staff are taught if a resident is resistive to either try another staff member or reapproach. I would have expected the CNA to stop and reapproach. 36192 Example 3: R7 was admitted on [DATE] with diagnosis that include hemiplegia (partial or total paralysis of one side) of right side and epilepsy (seizure disorder.) R7's Care Plan states in part: I have an ADL (activity of daily living) self-care performance deficit r/t (related to) hemiplegia d/t (due to) stroke with right side weakness. date initiated: [DATE] . interventions: Toilet use: I require min. (minimal) assistance by 1 staff for toileting. Use gait belt & stand pivot transfer [[DATE]]. Transfer: I require min. assistance SPT (stand pivot transfer), FWW (front wheeled walker) & gait belt by 1 staff to move between surfaces daily every shift and as necessary .I am unaware of my safety limitations and frequently self-transfer .revision on [DATE]. Focus: I am high risk for falls r/t gait/balance problems, worry about incontinence, unaware of safety d/t confusion/impulsive .revision [DATE] .ensure that I am wearing appropriate footwear non-skid socks or non-skid footwear when ambulating or mobilizing in w/c (wheel chair) . revision on: [DATE] . On [DATE] at 12:47 PM, Surveyor observed R7 to be in her bathroom alone using the restroom. R7 had her wheelchair parked in front of her facing the toilet and her shoes were off her feet and were under her wheelchair. Surveyor left R7's room to stand in the hallway to observe if staff were going to come assist R7. At 12:53 PM, Surveyor heard water running in R7's bathroom and Surveyor went to observe R7. R7 was now sitting in her wheelchair at the sink washing her hands. R7 did not have shoes or gripper socks on at this time, and her shoes were by the toilet. R7 propelled herself in her wheelchair back to her bed. R7 then self-transferred from her wheelchair to her bed. R7's call light was bumped when R7 returned to bed and RN C (Registered Nurse) came into R7's room at 12:56 PM and asked R7 if she needed anything, R7 shook her head no. RN C removed the foot pedals off R7's wheelchair. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525643	A. Building B. Wing	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant View Nursing Home	N3150 WI-81 Monroe, WI 53566

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 12:58 PM, Surveyor interviewed RN C regarding R7's self-transfer. RN C indicated R7 is not supposed to be up on her own and that even if you go in to offer help, she will still get up on her own. RN C indicated R7 should have gripper socks on. On [DATE] at 2:55 PM, Surveyor observed CNA D (Certified Nursing Assistant) pushing R7 down the hallway to activities in her wheelchair. R7 did not have gripper socks or non-skid footwear on her feet. R7 had Tubi grips on with normal socks over them. Surveyor asked CNA D if R7 had gripper socks on, CNA D stated regular socks. On [DATE] at 2:59 PM, CNA D indicated to Surveyor that she put gripper socks on R7 and that she should have had them on. On [DATE] at 9:00 AM, Surveyor interviewed DON B (Director of Nursing) regarding observations with R7. DON B indicated she would expect R7 to have appropriate footwear or gripper socks on and would expect CNAs to follow the care plan related to nonskid footwear. 39713 Example 4: R4 was admitted to the facility on [DATE] with diagnoses including, but not limited to, abnormal weight loss, chronic diastolic (Congestive) heart failure, COPD (Chronic Obstructive Pulmonary Disease), hypertensive heart disease with heart failure, and chronic pain. R4's most recent quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) of [DATE] indicates R4 is cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15 out of 15. R4 requires substantial/maximum assistance with shower/bath, toileting hygiene, upper body dressing, lower body dressing, personal hygiene, roll left to right, lying to sitting, sit to stand, chair/bed-to-chair transfers, and toilet transfers. R4 does not ambulate and is always continent of bowel and bladder. R4's care plan, dated [DATE], states, in part . Focus: I have an ADL (Activities of Daily Living) self-care performance deficit r/t (related to) right tibia fracture. Interventions: Transfer: I require assistance of 2 staff using mechanical lift to transfer from surface to surface. On [DATE] at 12:50 PM, Surveyor observed CNA M (Certified Nursing Assistant) and CNA P transfer R4 from bed to wheelchair with full body lift. R4 had the full body lift sling under her when Surveyor entered R4's room. CNA M hooked the sling to the full body lift as CNA P assisted in guiding R4 to wheelchair. Surveyor had no initial concerns with R4's transfer. Surveyor asked CNA M how staff determine what sling they are to use with each resident. CNA M stated it is based off weight. Surveyor asked CNA M what size sling is used for R4. CNA M stated I believe it is a large sling. Surveyor asked CNA M to show Surveyor how she would know that. CNA M took Surveyor over to R4 and pulled back the label on the sling which indicated the sling used for R4 was a Medium. CNA M stated, this is a medium sling, and we should have been using the large sling based off R4's weight. CNA M pulled out the document titled, EZ Way Sling Sizing Chart to show Surveyor how a sling size is determined. Surveyor asked CNA M how much R4 weighs. CNA M approached RN N to ask what R4's most current weight was. RN N stated, R4's weight on [DATE] was 255.2. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525643	A. Building B. Wing	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant View Nursing Home	N3150 WI-81 Monroe, WI 53566

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Note: According to the facility document titled, EZ Way Sling Sizing Chart a resident weighing 255 lbs. should use a size large sling. The medium sling being used was for weight ,d+[DATE] lbs. R4 exceeds the weight for the medium sling. On [DATE] at 3:05 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B how staff determine which sling is to be used with a full body lift. DON B stated it is based off the resident's weight. There is a sheet in a bag on each full body lift that shows the color of the sling based on the residents weight. The facility failed to ensure that staff were using the appropriate sling for lifts based on resident body weight. 29360 Example 5: R1 was admitted on [DATE]. R1's diagnoses include Alzheimer's, Behavioral Disturbances, and glaucoma. R1's most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] includes, in part, the following: R1 has severe cognitive impairment and can independently ambulate. R1's care plan Focus: I have the potential to be physically aggressive r/t (related to) Dementia, poor impulse control. I may communicate with others by striking out due to not aware how to communicate someone maybe endangering me (if someone is about to run over my feet over, I will draw attention by striking out, no initiation date, includes, in part, the following interventions: Continue monitoring my direction in care I turn around, [sic] Frequent checks. Document in (facility's charting system). If I am agitated, please distract me with an activity i.e., (such as) offer me a washcloth to wipe down railings in hallways. Monitor every shift. Document observed behavior and attempted interventions in behavior log. Monitor/document/report PRN (as needed) any s/sx (signs/symptoms) of me posing danger to self and others. My triggers for physical aggression are frustration or inability to communicate safely. My behaviors are (sic) de-escalated by walking outside, doing meaningful activities, such as cleaning, wiping hand rails, folding clothes, helping staff. I feel like I work here. Request I stop pushing residents in their wheelchairs and redirect me to another activity . When I become agitated: Intervene before agitation escalates. Guide me away from source of distress; Engage me calmly in conversation; if my response is aggressive staff to walk calmly away and approach me later. When (R1) starts grabbing for others; we will provide something for her to do with her hands i.e. Hold our hands, stuffed animal, baby. The facility's Alleged Nursing Home Resident Mistreatment, Neglect and Abuse Report, dated [DATE], 10:00 AM, includes, in part, the following: (R2) was in her wheelchair sitting in the doorway between Lane and View unit. Staff member was walking with (R1) through the doorway. Staff member positioned herself between the residents as they walked through. (R1) stopped to fix her shoe and (R2) reached around a staff member and hit (R1) on the face and across the shoulder. Neither (R2) or (R1) due to cognition were able to describe what happened to instigate the resident-to-resident altercation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525643	A. Building B. Wing	09/17/2024

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Pleasant View Nursing Home	N3150 WI-81 Monroe, WI 53566

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Alleged Nursing Home Resident Mistreatment, Neglect and Abuse Report, dated [DATE], 1:36 PM, includes, in part, the following: On [DATE] (CNA T) (Certified Nursing Assistant) was exiting a resident's room down the hall. (CNA T) saw (R1) trying to push (R2) down the hallway. (CNA T) asked (R1) to let go of the wheelchair, when she let go, she grabbed the railing with her right hand and grabbed (R2's) right arm with her left hand for stabilizations. (R2) started yelling and hit (R1) 3 times on left arm. (CNA T) separated residents immediately and (R2) was put in line of sight. Neither (R2) or (R1) recall the incident. Both denied pain, appeared calm sitting in the lounge area and no evidence of bruising at this time. The facility's Alleged Nursing Home Resident Mistreatment, Neglect and Abuse Report, dated [DATE], 4:00 PM, includes, in part, the following: (R12) reported to AA Q (Activity Aide) that (R1) pinched her in the left upper arm while in an activity. (R1) was seated next to (R12) at the activity and when AA Q turned around (R12) said (R1) pinched her. When AA Q turned back around (R1) was standing walking. It is believed that (R1) grabbed (R12's) arm when standing up possibly to stabilize herself. On [DATE] at 1:38 PM, CNA P (Certified Nursing Assistant) accompanied R1, who ambulated independently, to an activity in a common room at the end of Hill View unit. CNA P left R1 sitting at the table with other residents within reach. AA Q was in the room. 1:47 PM, AA Q left the room. R1 was left unsupervised with a resident on either side of her, sitting at the table within reach. 1:52 PM, AA Q returned to the room. On [DATE] at 3:20 PM, R1 was observed sitting in a common area in the middle of the units with another resident within reach of R1. There were no staff within line of sight or in the immediate area to monitor R1. On [DATE] at 3:30 PM, Surveyor interviewed DT R (Dementia Technician). DT R stated that R1 paces and can get agitated and weepy. When R1 shows behaviors of being agitated staff have to stay with R1. DT R stated she is aware of this happening two to three times a week. DT R states as long as staff know where R1 is staff do not have to be with her unless she is agitated. On [DATE] at 3:50 PM, Surveyor interviewed RN S (Registered Nurse). RN S stated R1 does not have a set time or a specific thing that sets off R1's agitation. Staff keep an eye on her and report to me when she becomes agitated. Example 6: R2 was admitted to the facility on [DATE]. R2's diagnosis include dementia, depression, and chronic pain. R2's most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] includes, in part, the following: R2 has severe cognitive impairment and wanders. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525643	A. Building B. Wing	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant View Nursing Home	N3150 WI-81 Monroe, WI 53566

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R2's Care Plan Focus: I have the potential to be physically and/or verbally aggressive r/t (related to) Dementia, Date Initiated: [DATE], Revised on: [DATE], includes, in part, the following interventions: Document observed behavior and attempted interventions. Monitor/document/report PRN (As Needed) any s/sx (Signs/Symptoms) of me posing danger to self and others. When I become agitated: Intervene before agitation escalates, guide me away from source of distress, engage me calmly in conversation, if my response is aggressive, staff to walk calmly away while continuing to ensure safety of myself and others, and approach me later. When resident showing signs of increased agitation including, but not limited to, elevated tone and volume of voice, negative vocalization, speech regarding her farm or money, violent speech, pacing, or clenching fists, nurse will implement frequent checks to ensure resident and other residents' safety. On [DATE] at 9:05 AM, R2 was observed in her wheelchair, in an activity on the unit, sitting within arm's reach of other residents. Activity staff were in and out of the room, leaving R2 unmonitored. On [DATE] at 6:30 AM, R2 was observed sitting in her wheelchair, other residents were in the area, no staff were within eyesight to monitor R2. Example 7: R6 was admitted [DATE]. R6's diagnosis include Alzheimer's, delusional disorder, depression, and chronic pain. R8's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of [DATE], includes, in part, the following: R6 has severe cognitive impairment. R6's Care Plan Focus: I have the potential to be physically aggressive (hitting, pinching, grabbing, running into staff with my wheelchair) r/t (related to) Dementia. History of harm to others. Poor impulse control. Date Initiated: [DATE], Revision on [DATE], includes, in part, the following interventions: When (R6) starts grabbing for others, we will provide something for her to do with her hands is hold our hands, stuffed animal, baby. Date initiated: [DATE]. When I appear distressed ex (example) Self propelling in the hallways steadily or reaching out to others, the floor nurse will assign a staff member to stay with her and keep others out of the way. Date initiated [DATE], Revision on: [DATE]. When I become agitated: Intervene before agitation escalates. Guide me away from source of distress. Engage me calmly in conversation. Date Initiated: [DATE], Revision on [DATE]. When I have increased anxiety and agitation, please try to redirect me to my room so I can lay down for a little while then reassess anxiety/agitation after that. Date Initiated: [DATE], Revision on: [DATE]. The facility's Alleged Nursing Home Resident Mistreatment, Neglect and Abuse Report, dated [DATE], 4:05 PM includes, in part, the following: (R6) grabbed (R1's) sleeve. Staff intervened and asked (R6) to let go of (R1's) sleeve. When (R6) let go; (R1) lost her balance and went down on left knee. (R6) will be checked by staff every 15 minutes to ensure that she is not near other residents at this time. The facility's Alleged Nursing Home Resident Mistreatment, Neglect and Abuse Report, dated [DATE], 11:57 AM, includes, in part, the following: (R6) was reaching for (R1) as she walked by. CNA (Certified Nursing Assistant) was there to intervene and stop (R6) before could make contact with (R1). CNA was thinking it was resolved. (R1) then turned and grabbed (R6's) shirt and scratched her on the left shoulder. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525643	A. Building B. Wing	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant View Nursing Home	N3150 WI-81 Monroe, WI 53566

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 4:30 PM, R6 was observed sitting up in her wheelchair in the hallway with other residents near R6. There were no staff in the hallway to monitor R6. Example 8: R5 was admitted on [DATE]. R5's diagnosis include dementia, anxiety, and depression. R5's most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] includes, in part, the following: R5 has severe cognitive impairment, physical behaviors towards others and verbal behaviors towards others. R5's Care Plan Focus: I have the potential to be physically aggressive (hitting others) r/t (related to) Dementia, Poor impulse control, Date Initiated: [DATE], includes, in part, the following interventions: Monitor each shift and as needed. Document observed behavior and attempted interventions in behavior log. Monitor/document/report PRN (as needed) any s/sx of me posing danger to self and others. If I am posing a threat to other residents have a staff member assigned to monitor or spend time with me. Resident has shown increased confusion and wandering into peers rooms, particularly after experiencing a sleepless night, absence seizure, pain that she is unable to express, or concerns with constipation. When I become agitated assign a staff member to stay with resident and intervene before agitation escalates. Guide me away from source of distress. Engage me calmly in conversation. If my response is aggressive, staff to walk calmly away, and approach me later. Initiating playing music will sooth me at times. Date initiated: [DATE]. Revision on: [DATE]. The facility's Alleged Nursing Home Resident Mistreatment, Neglect and Abuse Report, dated [DATE], includes, in part, the following: Date occurred: [DATE]. Time occurred: 12:45 PM. Brief Summary of Incident: (R1) were (sic) passing each other in the hallway when both (R1 and R5) started to slap each other and (R1) pull (sic) (R5's) hair. Staff intervened immediately and each resident was taken to their home area. Both (R1 and R5) have dementia and severe impairment. Both residents were assessed for injury and psychosocial effects. Neither resident had any indication of injury or effect, but they will continue to receive assessments for the next 7 days. Both residents will remain with staff on their resp [TRUNCATED]

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	525643	A. Building B. Wing	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33166 Based on observation, interview, and record review, the facility did not ensure hand hygiene and infection control practices were performed to prevent the spread of infection for 1 of 4 residents (R11) observed for hand hygiene and infection control opportunities. Staff were observed not completing hand hygiene per standards of practice, placing dirty washcloths in the wash basin, placing dirty washcloths on the bedside table, not disinfecting the bedside table or mechanical lift. This is evidence by: The facility policy titled Handwashing/Hygiene dated revised 8/2019 states in part; the facility considers hand hygiene the primary means to prevent the spread of infections. Policy Interpretation and Implementation: 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infection to other personnel, residents, and visitors. 3. Hand hygiene products and supplies shall be readily accessible and convenient for staff use to encourage compliance with hand hygiene polices. 6. Wash hands with soap and water for the following situations: a. When hands are visibly soiled. 7. Use an alcohol-based hand rub containing at least 62 % alcohol; or alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: a. before and after coming on duty. b. before and after direct contact with residents. h. before moving from a contaminated body site to a clean body site during resident care. i. after contact with residents intact skin j. after contact with blood or bodily fluids k. after handling used dressings or contaminated equipment. l. after contact with objects (e.g., medical equipment) in the immediate vicinity of the resident. m. after removing gloves. (continued on next page)

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	525643	A. Building B. Wing	09/17/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8. Hand hygiene is the final step after removing and disposing of personal protective equipment. Applying and removing gloves: 1. Perform hand hygiene before applying non-sterile gloves. 2. When applying, remove one glove from the dispensing box at a time, touching only the top of the cuff. 3. When removing gloves, pinch the glove at the wrist and peel away from the hand, turning the glove inside out. 4. Hold the removed glove in the gloved hand and remove the other glove by rolling it down the hand and folding it into the first glove. 5. Perform hand hygiene. R11 was admitted to the facility on [DATE] with diagnoses including hemiplegia secondary to Cerebrovascular Accident (paralysis after stroke). R11's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/3/24 indicates R11 is dependent on staff for care and transfers. On 9/16/24 at 10:30 AM, Surveyor observed personal care being provided to R11 by DON B (Director of Nursing) and CNA H (Certified Nursing Assistant). CNA H entered the room and did not perform Hand Hygiene (H/H) CNA H applied gloves and began performing peri care. R11 stated to CNA H, I am wet. CNA H used a clean washcloth from the wash basin and began providing peri care with soap and water. Once CNA H was completed peri care washing CNA H did not remove her gloves or perform H/H. With the same dirty gloves CNA H reached into the clean water basin to grab a washcloth to rinse R11, CNA H rinsed R11 with the washcloth and laid the wash cloth on the bedside stand. CNA H took a dry towel and patted R11 dry. DON B and CNA H rolled R11 on her side and R11 had visible stool on her bottom. CNA H with the same dirty gloves went into the wash basin and washed R11's bottom and removed the stool. CNA H threw the dirty wash cloth into the clean basin and with the same gloves took a washcloth out of now the soiled basin to rinse R11's bottom. CNA H at no time removed her gloves or performed H/H. CNA H with the same gloves grabbed a tube of barrier cream and placed on R11's bottom. CNA H then removed her right glove although did not perform H/H. DON B requested a clean washcloth for R11, and CNA H entered the bathroom did not remove her soiled glove or perform H/H wet a wash cloth, wrung the washcloth out and handed the washcloth to DON B and DON B used the wash cloth to wash R11's back. CNA H and DON B transferred R11 to her wheel chair. CNA H continued to have the soiled glove on her left hand. Once R11 was in the chair CNA H went to R11's bedside stand and grabbed R11's brush and began to brush R11's hair. CNA H was brushing R11's hair with her right hand and using her soiled, gloved left hand to run her fingers through R11's hair. CNA H put the brush back on the bedside stand removed her glove did not perform H/H. CNA H removed the wash basin helped R11 get settled into her chair and exited the room without performing H/H. CNA H did not disinfect the bedside stand despite having soiled washcloths on the bedside stand and did not disinfect the lift after use. (continued on next page)

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	525643	A. Building B. Wing	09/17/2024

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Pleasant View Nursing Home	N3150 WI-81 Monroe, WI 53566

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/16/24 at 10:55 AM Surveyor spoke with CNA H regarding infection control practices and hand hygiene. Surveyor asked CNA H when she should wash her hands. CNA H stated when entering a room, when visibly soiled, after removing gloves and when ever dirty. Surveyor asked CNA H if she washed her hands upon entering R11's room CNA H stated she did not. Surveyor asked CNA H if she removed her gloves or performed H/H after providing peri care CNA H stated she did not. Surveyor asked CNA H if she disinfected the bedside stand of lift after use CNA H stated she did not and she should have. On 9/17/24 at 9:00 AM Surveyor interviewed DON B regarding the H/H opportunities with CNA H. DON B stated she did realize CNA H placed a dirty washcloth in the wash basin and asked CNA H to get a clean washcloth. DON B did not realize there were missed H/H opportunities. Surveyor shared the observations made and DON B stated she would have expected H/H when going from dirty to clean and when removing gloves or whenever soiled. DON B stated she would expect the bedside table and lift to be disinfected after use.