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	10/09/2024

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 0560 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect a residents' right to refuse some types of non-requested transfers within the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33166 Based on interview and record review the facility did not afford the resident or resident's representative the right to refuse to transfer to another room in the facility for 3 of 3 residents (R1, R2 and R3) reviewed for room transfers. R1, R2, and R3 received room change notices and the facility did not afford the residents' representatives the opportunity to refuse the room change. This is evidenced by: The facility's policy titled Room Change/Roommate Assignment revised 3/2021 states in part; changes in room or roommate assignment are made when the facility deems it necessary or when the resident requests the change. 1. Resident room or roommate assignment may change if the facility deems it necessary. Resident preferences are taken into account when such changes are considered. 2. Room changes initiated by the facility are limited to moves with the same building in which the resident currently resident resides unless the resident voluntarily agrees to move to another building within the same facility. Prior to changing a room or roommate assignment all parties involved in the change/ assignment (e.g., residents and their representatives) are given at least a 4-hour advance notice of such change. 5. Residents have the right to refuse to move to another room in the facility if the purpose of the move is: a. to relocate a resident of a skilled nursing unit within the facility to one that is not a skilled nursing unit; b. to relocate a resident of a nursing unit with the facility to one that is a skilled nursing unit; or solely for the convenience of staff. The facility posted a sign dated 9/30/24 for all staff the sign states in part; In response to the last survey visit on 9/16/24. The only way to guarantee other residents are safe; we have issued a 30-day notice to (R1) and (R2). (R1), (R2) and (R3) will be housed in the Way unit. Not ideal but in order for us to have a chance of being cleared, this needs to happen. Example 1 R1 was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease, Seizure disorder, Depression, and Insomnia. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525643	A. Building B. Wing	10/09/2024

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 0560 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Quarterly Minimum Data Set (MDS) dated [DATE] indicates R1 has a Brief Interview of Mental Status (BIMS) of 0 out of 15, indicating R1 is severely cognitively impaired Section E indicates that out of the last 7 days R1 has behavioral symptoms toward others 1-3 days, Verbal Symptoms toward others 1-3 days, behavioral symptoms not directed toward other 1-3 days, rejection of care 1-3 days and wanders 1-3 days. Impact to Resident and other residents is blank. Section GG indicates R1 is dependent for toileting hygiene, showers, upper and lower body dressing, and personal hygiene. On 9/27/24, the facility issued a document to R1's husband that states in part: Facility-Initiated Room Transfer. Resident Name: (R1). Date of written notice given or mailed: 9/27/24 (per phone). Resident Representative Name: FM S (Family Member) name, R1's AHCPOA (Activated Health Care Power of Attorney). This is to notify you of an upcoming move with the facility to another room within the facility. You will be moved from Room Number (room number) on Lane Unit to Room Number (Room Number) on the Way unit. The expected move date is 9/30/24. Family friends are welcome to assist with the move, but staff are available to move belongings as needed. The purpose of the move: Smaller unit to control behaviors affecting others and allow wandering. (Facility Name) understand that moving rooms can be a big change for some individuals, and every care is taken in making the right decision for all of our residents. However, you do have the right to contest this decision and contact your local Ombudsman about this move. The Ombudsman covering this area is: The Ombudsman for [NAME] County is: (Ombudsman C's Name) Email: (Email address) and Phone (Phone Number). On 10/8/24 at 8:12 PM, Surveyor interviewed FM J (Family Member) regarding R1's FIRC (Facility-Initiated Room Change). FM J stated on Friday 9/27/24, the facility contacted (R1's) AHCPOA FM S regarding the FIRC. FM S was told that R1 and two other residents would be moving to a different part of the facility. FM S received this call late in the afternoon on Friday 9/27/24. FM J stated FM S was not given an explanation for the reason for the transfer and the family did not know why this was occurring. Surveyor asked FM J if she or FM S were given the right to refuse the room transfer and FM J stated I did not hear we had that right. It happened quickly and (R1) was moved early Monday morning. On 10/9/24 at 10:00 AM, Surveyor met with FM S and FM J. FM S stated he received a call on Friday that they were moving (R1); I do not recall if they stated why. I was told I had to come in and sign a paper before Monday which I did. Surveyor asked FM S do you recall the facility mentioning to you, you could refuse the transfer. FM S stated he was not aware he could refuse. FM J stated it all happened so fast we wouldn't have known we had the right to refuse. Example 2 R2 was admitted on [DATE] with diagnosis that include Alzheimer's, Dementia, muscle weakness and unsteadiness on feet. R2's Quarterly Minimum Data Set (MDS) dated [DATE] indicates R2 has a Brief Interview of Mental Status (BIMS) of 0 out of 15, indicating R2 is severely cognitively impaired. Section B indicates R2 hears adequately, has clear speech, usually makes self-understood, and usually understands others. Section E indicates that R2 has not had rejection of cares, physical, verbal, or other behavioral symptoms, or wandering in the last 7 days. Impact to Resident and other residents is blank. Section GG indicates R2 needs supervision or touching assistance with toileting hygiene, showers, lower body dressing and personal hygiene. R2 is independent with sitting to lying, lying to sitting, sitting to standing and transferring from chair to bed or bed to chair, toileting, and walking. (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	10/09/2024

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 0560 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/27/24, the facility issued a document to R2's responsible party that states in part: Facility-Initiated Room Transfer. Resident Name: (R2). Date of written notice given or mailed: 9/27/24 (per phone). Resident Representative Name: FM K (Family Member) name, R2's Guardian. This is to notify you of an upcoming move with the facility to another room within the facility. You will be moved from Room Number (room number) on Lane Unit to Room Number (Room Number) on the Way unit. The expected move date is 9/30/24. Family friends are welcome to assist with the move, but staff are available to move belongings as needed. The purpose of the move: Smaller unit to control behaviors affecting others and allow wandering. (Facility Name) understand that moving rooms can be a big change for some individuals, and every care is taken in making the right decision for all of our residents. However, you do have the right to contest this decision and contact your local Ombudsman about this move. The Ombudsman covering this area is: The Ombudsman for [NAME] County is: (Ombudsman C's Name) Email: (Email address) and Phone (Phone Number). On 10/9/24 at 8:55 AM, Surveyor interviewed FM K regarding R2's FIRC (Facility-Initiated Room Change). FM K stated she received a call on Friday 9/27/24 at approximately 3:30. FM K stated she was on vacation up north when she received the call from SW R (Social Worker). FM K stated she was told the facility was moving (R2) to see how that would work to prevent incidents. FM K stated I thought this was awful (R2) has severe dementia and moving her would likely make things worse not better. FM K stated she was also told on Friday if this did not work the facility would be requesting the family look at moving (R2) elsewhere. Surveyor asked FM K if she was told she had the right to refuse the room change and FM K stated she did not receive that information. I was only told I needed to sign the paper by Monday. I came in Sunday night and signed the paperwork. FM K stated I came in very, early Monday morning and was shocked they had already moved (R2) to the other unit. I wouldn't even have had time to refuse the move. Example 3 R3 was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease, chronic pain, delusional disorders, major depression, anxiety, and adjustment disorder. R3's Quarterly Minimum Data Set (MDS) dated [DATE] indicates R3 has a Brief Interview of Mental Status (BIMS) of 0 out of 15, indicating R3 is severely cognitively impaired Section E indicates that out of the last 7 days 1-3 days, behavioral symptoms not directed toward other. Section GG indicates R3 is supervision/maximum assistance for toileting hygiene, showers, dressing, and personal hygiene. On 9/27/24 the facility issued a document to R3's AHCPOA (Activated Health Care Power of Attorney) FM L (Family Member) that states in part: Facility-Initiated Room Transfer. Resident Name: (R3). Date of written notice given or mailed: 9/27/24 (per phone). Resident Representative Name: FM L (name). This is to notify you of an upcoming move with the facility to another room within the facility. You will be moved from Room Number (room number) on Lane Unit to Room Number (Room Number) on the Way unit. The expected move date is 9/30/24. Family friends are welcome to assist with the move, but staff are available to move belongings as needed. The purpose of the move: Smaller unit to control behaviors affecting others and allow wandering. (Facility Name) understand that moving rooms can be a big change for some individuals, and every care is taken in making the right decision for all of our residents. However, you do have the right to contest this decision and contact your local Ombudsman about this move. The Ombudsman covering this area is: The Ombudsman for [NAME] County is: (Ombudsman C's Name) Email: (Email address) and Phone (Phone Number). (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	10/09/2024

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 0560 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/9/24 at 2:30 PM, Surveyor interviewed FM L regarding R3's room transfer. FM L stated the facility was upfront with her and she did not have a concern with the R3's room transfer. On 10/9/24 at 8:35 AM, Surveyor interviewed SW R (Social Worker) regarding the room changes for R1, R2, and R3. SW R stated she called the families on Friday 9/27/24 and told them the residents would be moved on Monday and families needed to come in and sign paperwork. Surveyor asked SW R did the facility give the resident representatives the right to refuse the room transfer. SW R stated it was on the paperwork, Surveyor asked if this was relayed to the families and SW R stated it was. On 10/9/24 at 5:50 PM, Surveyor interviewed NHA A (Nursing Home Administrator) regarding the room changes. NHA A stated the room changes were necessary as there were gaps in staff supervision of the three residents. NHA A stated the IDT (Interdisciplinary Team) met and decided to make the room changes to lower the ratio from staff to resident and try to protect the residents. Surveyor asked if the families had the right to refuse the room transfer NHA A stated it was written on the form. We told families on Friday afternoon, left papers at the front desk for the families to sign, and moved the residents on Monday.

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	10/09/2024

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 33166 Based on observation and interview, the facility did not ensure that each resident has a safe, clean, comfortable, and homelike environment, including, but not limited to receiving treatment and supports for daily living for 1 (R2) of 3 resident rooms observed. R2's bathroom toilet was soiled with stool and family reported it had been soiled for several days. This is evidenced by: On 10/8/24 at 6:45 PM, Surveyor observed R2's room and bathroom. R2's toilet was soiled with stool. On 10/9/24 8:20 AM, Surveyor observed R2's room and bathroom. R2's toilet was soiled with stool. On 10/9/25 at 8:15 AM, Surveyor met R2's Guardian FM K (Family Member) and Spouse. R2's guardian asked Surveyor if she had observed R2's bathroom. Surveyor observed R2's bathroom and noted the bathroom remained dirty with stool observed around and in the stool. FM K stated this has been like this for several days; the facility does not clean R2's bathroom or room. FM K stated she has had to clean R2's room because the facility does not. On 10/9/24 at 8:30 AM, Surveyor interviewed Hskp BB (Housekeeping) regarding cleaning of resident rooms. Hskp BB stated rooms are usually cleaned daily. Surveyor asked Hskp BB if she was aware R2's bathroom needed cleaning. Hskp BB stated she was not but would clean it if necessary. On 10/9/24 at 5:50 PM, Surveyor interviewed NHA A (Nursing Home Administrator) regarding R2's bathroom. NHA A stated it has been cleaned.

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	10/09/2024

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 0603 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33166 Based on observation, interview, and record review the facility failed to ensure 3 of 3 residents (R1, R2, and R3) were free from involuntary seclusion. The facility moved R1, R2, and R3 from the unit they resided on and placed them on a different unit within the facility. Facility staff erected a wall and placed R1, R2, and R3 behind this wall. R1, R2, and R3's families were not aware R1, R2, and R3 were being secured behind a wall isolating the residents from others in the facility. Using the reasonable person concept a resident would be fearful, anxious and feel dehumanized, when not afforded the individuality, compassion and civility as others who reside at the facility. As the Psychosocial Outcome Severity Guide, located in the Nursing Home Survey Resources Folder, describes, to apply the reasonable person concept, the survey team should determine the severity of the psychosocial outcome or potential outcome the deficiency may have had on a reasonable person in the resident's position (i.e., what degree of actual or potential harm would one expect a reasonable person in the resident's similar situation to suffer as a result of the noncompliance). Generally, when applying the reasonable person concept, the survey team should consider the following as it determines the outcome to the resident, which include, but is not limited to: The resident may consider the facility to be their home, where there is an expectation that he/she is safe, has privacy, and will be treated with respect and dignity. The resident trusts and relies on facility staff to meet his/her needs. The resident may be frail and vulnerable. This is evidenced by: The State Operations Manual states in part: Involuntary seclusion is defined as separation of a resident from other residents or from her/his room or confinement to her/his room (with or without roommates) against the resident's will or the will of the resident representative. NOTE: During a situation in which a resident's behavior has escalated and immediate interventions are required for the safety of the resident, staff and/or other residents, the facility must immediately consult with the resident's physician about the behavioral symptoms and the resident's designated representative; and provide necessary supervision of the resident to ensure that the resident and other residents are protected. Involuntary seclusion may take many forms, including but not limited to the confinement, restriction, or isolation of a resident. Involuntary seclusion may be a result of staff convenience, a display of power from the caregiver over the resident or may be used to discipline a resident for wandering, yelling, repeatedly requesting care or services, using the call light, disrupting a program or activity, or refusing to allow care or services such as showering or bathing to occur. (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	10/09/2024

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 0603 Level of Harm - Actual harm Residents Affected - Few	Involuntary seclusion includes, but is not limited to, the following: A resident displays disruptive behaviors, such as yelling, screaming, distracting others (such as standing and obstructing others viewing abilities for the TV or programs) and staff remove and seclude the resident in a separate location such as in an office area or his/her room, leaving and closing the door and without providing interventions to address the behavioral symptoms. In an attempt to isolate a resident to prevent him/her from leaving an area, the resident(s) is involuntarily confined to an area by staff placing furniture, carts, chairs in front of doorways or areas of egress. Staff place a resident in a darkened room, office, or area secluded from other staff and residents for convenience or as punishment. A resident placed in a secured area of the facility but does not meet the criteria for the unit and is not provided with access codes or other information for independent egress. Considerations Involving Secured/Locked Areas If a resident resides in a secured/locked area that restricts a resident's movement throughout the facility, the facility must ensure that the resident is free from involuntary seclusion. The facility involves the resident/representative in care planning, including the decision for placement in a secured/locked area and the development of interventions based upon the resident's comprehensive assessment and needs; and the facility provides immediate access and visitation by family, resident representative, or other individuals, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent. It is expected that each resident's record would include: documentation of the clinical criteria met for placement in the secured/locked area by the resident's physician along with information provided by members of the interdisciplinary team; documentation that reflects the resident/representative's involvement in the decision for placement in the secured/locked area; documentation that reflects whether placement in the secured/locked area is the least restrictive approach that is reasonable to protect the resident and assure his/her health and safety; documentation by the interdisciplinary team of the impact and/or reaction of the resident, if any, regarding placement on the unit; and ongoing documentation of the review and revision of the resident's care plan as necessary, including whether he/she continues to meet the criteria for remaining in the secured/locked area, and if the interventions continue to meet the needs of the resident. NOTE: A resident who chooses to live in the secured/locked unit (e.g., the spouse of a resident who resides in the area), and does not meet the criteria for placement, must have access to the method of opening doors independently. The chosen method for opening doors (e.g., distribution of access code information) is not specified by the Center of Medicare and Medicaid Services. The facility posted a sign dated 9/30/24 for all staff, the sign states in part; In response to the last survey visit on 9/16/24. The only way to guarantee other residents are safe; we have issued a 30-day notice to (R1) and (R2). (R1), (R2) and (R3) will be housed in the Way unit. Not ideal but for us to have a chance of being cleared, this needs to happen. (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	10/09/2024

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 0603 Level of Harm - Actual harm Residents Affected - Few	The Division of Quality Assurance is in receipt of photos of a large blue wall that appears affixed to the cement wall. Additionally, DQA received photos of yellow accordion floor signs and an armed chair that are placed in front of the fire doors in what appears an effort to block exit through these doors. On 10/8/24 at 6:00 PM, Surveyor entered the lobby area on the main floor of the facility. Surveyor walked down the hall and immediately observed a large blue paneled wall erected across the hallway on the Way unit. The wall was approximately 6 feet high and secured to the cement wall with a metal bracket. The hallway where the wall was erected was very gloomy and dark. Surveyor could hear a staff member speaking to a resident but could not see a way to open the wall or get onto the Way unit. Surveyor walked down the hall and found a nurse who called the nurse manager. On 10/8/24 at 6:10 PM, Surveyor interviewed NM M (Nurse Manager) regarding the wall. Surveyor asked NM M what the purpose of the wall was. NM M stated 3 residents were moved to the unit and the wall was erected to keep the residents on the hall so they would not wander off the unit. Surveyor asked NM M how families get behind the wall to see their loved ones. NM M stated families would let someone know they are coming or are here and staff can assist them to get onto the unit. Surveyor asked NM M what would staff do in the event of an emergency or fire. NM M stated someone would be at the front of the building and let EMS (Emergency Medical Services) or fire in to the building and behind the wall. Staff can open the wall and residents can walk off the unit. Surveyor asked NM M if she was aware if families were upset by this move. NM M stated she had not heard families were upset. On 10/8/24 at 6:30 PM, Surveyor met DON B (Director of Nursing) and asked how Surveyor could get onto the Way unit. DON B took Surveyor onto the elevator and went up to the DSU (Dementia Stabilization Unit), Surveyor and DON walked through the DSU and down the stairs and onto the Way unit. Surveyor asked DON B how family members get to the Way unit. DON B stated family members can take the same route we just did. It should be noted two of the residents on the Way unit have elderly spouses who visit. On 10/8/24 at 6:33 PM, Surveyor entered the Way unit with DON B. The Way unit had one CNA, CNA N (Certifed Nursing Assistant) on the unit. R3 was up in her wheel chair and R1 and R2 were in bed. Surveyor noted the fire doors at the end of the hall were open and the blue wall was just beyond the fire doors. Surveyor noticed a tab alarm affixed to the door jamb of R1's door with a string attached to the magnet affixed to the alarm box. Surveyor asked DON B what the tab alarm was for. DON B stated we can pull R1's door shut and attach the string to the door and then leave the door slightly ajar. If R1 gets up and opens the door the alarm will sound, and we know R1 is up. It should be noted the string was not attached to the door and R1 was in her bed at the time of this observation. DON B walked down the hall with Surveyor and showed Surveyor if you close the fire doors there was a box affixed to the fire doors and a string that attached to the fire door handles. If the string is attached to the handles and the door is opened a call alarm goes off at the kiosk at the end of the hall indicating the fire doors have been opened. Surveyor asked CNA N if she was aware if families were upset by this move. CNA N stated she had not heard families were upset. (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	10/09/2024

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 0603 Level of Harm - Actual harm Residents Affected - Few	On 10/8/24 at 6:35 PM, Surveyor interviewed CNA N (Certified Nursing Assistant) regarding the residents on the Way unit. Surveyor asked CNA N if she knew why the residents were on the Way unit behind the wall. CNA N stated the 3 residents R1, R2, and R3 had been involved in several resident-to-resident incidents and they were moved to the Way unit for their safety and other residents safety. Surveyor asked CNA N if the residents are able to go off the unit for activities. CNA N stated there is a few things here we can do with the residents. CNA N pointed to a book case with coloring books, books, a radio and stated there is TV. Surveyor asked how the residents families get on to the unit to visit. CNA N stated families do not have to do the stairs there is a way to open the wall up from the middle to let staff and visitors on and off the unit. Surveyor asked CNA N what she would do in the event of an emergency. CNA N stated she has a phone and can call for assistance. Surveyor asked what you would do in the event of a fire or an emergency requiring EMS. CNA N stated she can open the wall and let EMS or fire onto the unit, or she can take the residents off the unit. Example 1 R1 was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease, Seizure disorder, Depression, and Insomnia. R1's Quarterly MDS (Minimum Data Set) dated 9/18/24 indicates R1 has a BIMS (Brief Interview of Mental Status) of 0 out of 15, indicating R1 is severely cognitively impaired Section E indicates that out of the last 7 days R1 has behavioral symptoms toward others 1-3 days, Verbal Symptoms toward others 1-3 days, behavioral symptoms not directed toward other 1-3 days, rejection of care 1-3 days and wanders 1-3 days. Impact to Resident and other residents is blank. Section GG indicates R1 is dependent for toileting hygiene, showers, upper and lower body dressing, and personal hygiene. R1's care plan states in part; Focus: Daily preferences of care. Goal: I will be satisfied with care provided. Interventions: Interventions it is very important to me to have my husband and my daughter involved in care and discussions. R1's care plan states in part; Focus: I am dependent on staff for meeting my emotional, intellectual, physical, and social needs related to dementia and cognitive deficits. Goal: I will maintain involvement in cognitive stimulation, social activities as desired. Interventions: I need assistance with ADLs (activities of daily living) as required during the activity. I need escort to activity functions. I prefer activities which do not involve overly demanding cognitive tasks. Engage in simple, structured activities such as music, crafts, and baking. Introduce me to residents with similar background, interests, and encourage/facilitate interaction. Invite me to scheduled activities. (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	10/09/2024

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 0603 Level of Harm - Actual harm Residents Affected - Few	R1's care plan states in part; Focus: I have the potential to be physically aggressive (hitting other) related to dementia, poor impulse control. Goal: I will not harm self or others. Interventions: Ask resident what can be done to help her feel better. Make sure resident feels reassured and in a safe environment where she can feel comfortable in her surroundings. Allow 15 minutes for resident to calm herself, rest in bed if tired, or all ow time for as needed work. Provide calm environment. I require frequent checks throughout the day and an alarm on my door to notify staff when I come out into the hallway. Monitor each shift and as needed, document observed behavior and attempted interventions in behavior log. Monitor/document/report as needed any signs and symptoms of me posing danger to self and others, If I am posing a threat to other residents have a staff member assigned to monitor me 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, if increased restlessness and wandering consider providing reassurance, acknowledge feelings, ensure safety of peers if wandering into other rooms or off unit. Staff should be calm and polite in redirectable attempt. If resident is not responding, use positive excitement to have resident follow you to a safe area rather than trying to physically redirect resident. Physically redirecting resident when she is in heightened state may exacerbate defensive response and lead to resident being more resistant to go in your direction, or even strike out. When I become agitated assign a staff member to staff with resident. R1's care plan states in part; Focus: I need placement in dementia specific facility to meet my needs of safety. Goal: My discharge goals are dementia specific facility. Interventions: Social Services to coordinate discharge to dementia specific placement. Support to be provided to family regarding changes occurring. R1's progress notes state the following: 10/2/2024 15:47 (3:47 PM) Facility initiated room change form and facility-initiated discharge notices were emailed to (Ombudsman Name) this date. On 9/27/24 the facility issued a document to R1's husband that states in part: Facility-Initiated Room Transfer. Resident Name: (R1). Date of written notice given or mailed: 9/27/24 (per phone). Resident Representative Name: FM S (Family Member) name, R1's AHCPOA (Activated Health Care Power of Attorney). This is to notify you of an upcoming move within the facility to another room with the facility. You will be moved from Room Number (room number) on Lane Unit to Room Number (Room Number) on the Way unit. The expected move date is 9/30/24. Family friends are welcome to assist with the move, but staff are available to move belongings as needed. The purpose of the move: Smaller unit to control behaviors affecting others and allow wandering. (Facility Name) understand that moving rooms can be a big change for some individuals, and every care is taken in making the right decision for all of our residents. However, you do have the right to contest this decision and contact your local Ombudsman about this move. The Ombudsman covering this area is: The Ombudsman for [NAME] County is: (Ombudsman C's Name) Email: (Email address) and Phone (Phone Number). (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	10/09/2024

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 0603 Level of Harm - Actual harm Residents Affected - Few	On 10/8/24 at 8:12 PM Surveyor interviewed FM J (Family Member) regarding R1's FIRC (Facility-Initiated Room Change). FM J stated on Friday 9/27/24, the facility contacted (R1's) AHCPOA FM S regarding the FIRC. FM S was told that R1 and two other residents would be moving to a different part of the facility. FM J stated FM S was not given and explanation for the reason for the transfer and the family did not know why this was occurring. Surveyor asked FM J if the family was aware R1 was going to be housed behind a wall and placed in a location without contact with others in the facility. FM J stated the facility did not share there would be a wall erected and (R1) would be housed behind the wall. FM J stated her, and her sister came to visit on Saturday 9/28/24, and they were absolutely mortified this was a huge shock to see the location (R1) was being housed. FM J stated it was dark back on the hall and they had no idea a large wall was up and (R1) was being kept behind a wall. FM J stated my sister, and I just could not believe what we were seeing. Surveyor asked how you and your sister got back onto the Way unit. FM J stated she was aware of how these partitions work and she kept looking for a place to pull the partition apart FM J stated she finally found a place and opened it up and her and her sister walked back on to the Way unit. FM J stated (R1) seemed very withdrawn she was not herself. FM J stated R1 was on her bed looking up at the ceiling and just staring this was very unlike her she is almost always up and out of her room. FM J stated we were just so shocked when we saw this unit and were very concerned about the lack of interaction and activity stimulation. It was all just so shocking I really don't have words for how we felt about the situation except completely saddened and shocked. On 10/9/24 at 8:15 AM Surveyor observed R1 to be in her room lying on her bed and looking up at the ceiling. R1 received her meal about 8:25 AM and was lying in bed and would lean over and fed herself bites at a time. On 10/9/24 at 8:40 AM Surveyor observed R1 up in the hall ambulating with her walker. Example 2 R2 was admitted on [DATE] with diagnosis that include Alzheimer's, Dementia, muscle weakness and unsteadiness on feet. R2's Quarterly MDS (Minimum Data Set) dated 10/1/24 indicates R2 has a BIMS (Brief Interview of Mental Status) of 0 out of 15, indicating R2 is severely cognitively impaired. Section B indicates R2 hears adequately, has clear speech, usually makes self-understood, and usually understands others. Section E indicates that R2 has not had rejection of cares, physical, verbal, or other behavioral symptoms, or wandering in the last 7 days. Impact to Resident and other residents is blank. Section GG indicates R2 needs supervision or touching assistance with toileting hygiene, showers, lower body dressing and personal hygiene. R2 is independent with sitting to lying, lying to sitting, sitting to standing and transferring from chair to bed or bed to chair, toileting, and walking. On 9/27/24 the facility issued a document to R2's responsible party that states in part: Facility-Initiated Room Transfer. Resident Name: (R2). Date of written notice given or mailed: 9/27/24 (per phone). Resident Representative Name: FM K (Family Member) name, R2's Guardian. This is to notify you of an upcoming move within the facility to another room with the facility. You will be moved from Room Number (room number) on Lane Unit to Room Number (Room Number) on the Way unit. (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	10/09/2024

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 0603 Level of Harm - Actual harm Residents Affected - Few	On 10/9/24 at 8:55 AM Surveyor interviewed FM K regarding R2's FIRC (Facility-Initiated Room Change). FM K stated she received a call on Friday 9/27/24 at approximately 3:30. FM K stated she was on vacation up north when she received the call from SW R (Social Worker). FM K stated she was told the facility was moving (R2) to see how that would work to prevent incidents. FM K stated I thought this was awful (R2) has severe dementia and moving her would likely make things worse not better. FM K stated she was also told on Friday if this did not work the facility would be requesting the family look at moving (R2) elsewhere. Surveyor asked FM K if she was aware R2 would be housed behind a wall. FM K stated I was not aware and was beside myself when I saw the wall, it's just terrible. Surveyor asked FM K how you were able to get back on the unit. FM K stated a staff member helped her onto the unit and now she knows how to separate the wall and does it herself. FM K stated there is not enough staff back on the unit, little stimulation and it is terrible how they are back on this unit alone. FM K stated she came to the facility on Monday morning after the move and R2 was beside herself, very disoriented to her new surroundings. FM K stated we were told that (R2) needed to move as the facility was unhappy about the number of incidents (R2) was involved in. The facility stated they were providing 1:1 staffing to prevent the incidents, but I never saw that. We were told the facility was receiving too many citations. This is all just very upsetting and wrong. Example 3 R3 was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease, chronic pain, delusional disorders, major depression, anxiety, and adjustment disorder. R3's Quarterly MDS (Minimum Data Set) dated 9/10/24 indicates R3 has a BIMS (Brief Interview of Mental Status) of 0 out of 15, indicating R3 is severely cognitively impaired Section E indicates that out of the last 7 days 1-3 days, behavioral symptoms not directed toward other. Section GG indicates R3 is supervision/maximum assistance for toileting hygiene, showers, dressing, and personal hygiene. R3's care plan states in part; Focus: daily Preferences of Activities. Goal: I will be satisfied with activities provided. Inteventions: It is important to me, but I am unable to do my favorite activities due to Alzheimer's. It is important to me, but I am unable to go outside to get fresh air when the weather is good due to Alzheimer's. R3's care plan states in part; Focus: I am dependent on staff for meeting my emotional, intellectual, physical, and social needs related to advanced Alzheimer's. Goal: I will attend/ participate in activities as able. Interventions: I need escort to activity functions. I prefer activities which do not involve overly demanding cognitive tasks. Engage in simple, structured activities. Invite me to scheduled activities. My preferred activities are 1:1, sitting gin the common area with groups of people, listening to music, walking with a staff member, rolling a yarn ball, caring for baby doll. R3's care plan states in part; Focus: I have the potential to be physically aggressive (hitting, pinching, grabbing, running into staff with my wheelchair) related to dementia, history or harm to others, poor impulse control. Goal: I will not harm others. Interventions: (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	10/09/2024

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 0603 Level of Harm - Actual harm Residents Affected - Few	Analyze times of day, places, circumstances, triggers, and what de-escalates behavior and document. Assess contributing sensory deficits. Assess and anticipate my needs. Complete frequent checks. Modify environment, adjust room temperature to comfortable level, reduce noise, dim lights, place familiar objects in room keep door closed. Monitor and document me posing harm to self or others. When starts grabbing for others' we will provide something for her to do with her hands i.e. hold our hands, stuffed animal, baby. When I appear distressed ex. 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. When I become agitated intervene before agitation escalates guide me away from source of distress engage me calmly in conversation. When I have increased anxiety and agitation pleas try to redirect me to my room so I can lay down for a little while then reassess anxiety/agitation after that. On 9/27/24 the facility issued a document to R3's AHCPOA (Activated Health Care Power of Attorney) FM L (Family Member) that states in part: Facility-Initiated Room Transfer. Resident Name: (R3). Date of written notice given or mailed: 9/27/24 (per phone). Resident Representative Name: FM L (name). This is to notify you of an upcoming move within the facility to another room with the facility. You will be moved from Room Number (room number) on Lane Unit to Room Number (Room Number) on the Way unit. The expected move date is 9/30/24. On 10/9/24 at 2:30 PM Surveyor interviewed FM L regarding R3's room transfer and if she was aware the facility was placing R3 behind a wall. FM L stated the facility was upfront with her and she did not have a concern with the R3's room transfer or where R3 was being housed. On 10/9/24 at 6:30 AM Surveyor interviewed CNA P regarding her knowledge of moving R1, R2 and R3 to the Way unit. CNA P stated she was told there were safety concerns with resident-to-resident incidents and wandering. This area would have less activity, be a calmer environment and would allow R1, R2 and R3 the freedom to wander. Surveyor asked CNA P what she would do in the event of an emergency. CNA P stated she has a phone and can call for assistance. Surveyor asked what you would do in the event of a fire or an emergency requiring EMS. CNA P stated she can open the wall and let EMS or fire onto the unit, or she can take the residents off the unit. Surveyor asked CNA P if families were supportive of the move or the wall. CNA P stated she has not heard families had a concern with the move or the wall. On 10/9/45 at 6:45 AM Surveyor interviewed RA/CNA Q (Resident Assistant/Certified Nursing Assistant) regarding her knowledge of moving R1, R2 and R3 to the Way unit. RA/CNA Q stated she was told there were behavior issues on the other unit the R1, R2 and R3 resided on before the move to the Way unit. RA/CNA Q stated the thought was moving the 3 residents to this unit would allow for closer observation and hope to reduce behaviors. Surveyor asked RA/CNA Q what she would do in the event of an emergency. RA/CNA Q stated she has a phone and can call for assistance. Surveyor asked what you would do in the event of a fire or an emergency requiring EMS. RA/CNA Q stated she can open the wall and let EMS or fire onto the unit, or she can take the residents off the unit. Surveyor asked RA/CNA Q if families were supportive of the move or the wall. RA/CNA Q stated she knows that R2's husband was very upset about the entire situation, and she referred him to social services. (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	10/09/2024

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 0603 Level of Harm - Actual harm Residents Affected - Few	On 10/9/24 at 8:35 AM Surveyor interviewed SW R (Social Worker) regarding the room changes for R1, R2 and R3. SW R stated she called the families on Friday 9/27/24 and told them the residents would be moved on Monday. Surveyor asked were families made aware the residents would be isolated on the unit behind a wall. SW R stated the wall was not initially put up; it was felt the residents needed more room to wander so the wall was put up to allow the residents more freedom. Surveyor asked SW R whose decision was it to erect the wall. SW R stated the IDT (Interdisciplinary Team) met and it was discussed, and the team all agreed this would allow the residents more freedom to wander. Surveyor asked SW R did anyone discuss the wall being erected with the families. SW R stated I am not sure. On 10/9/24 at 5:50 PM Surveyor interviewed NHA A (Nursing Home Administrator) regarding the room changes and the wall. NHA A stated the room changes were necessary as there were gaps in staff supervision of the three residents. NHA A stated the IDT met and decided to make the room changes to lower the ratio from staff to resident and try to protect the residents. Surveyor asked NHA A who decided to erect the wall. NHA A stated initially the staff had the fire doors closed and it was not allowing the residents enough space to wander. I ultimately made the decision; however, the IDT discussed the issue and we decided this would allow a safe space for the residents to walk and give them more freedom to walk the hall. We were acting on the best interest of the residents we did this to allow them more freedom. I feel like we just cannot make the right decision we need to protect residents but now are being told they cannot be in the space; I have no idea what we should do anymore. Surveyor asked NHA A if the families were told their loved ones would be behind the wall, NHA A stated yes. Surveyor asked NHA A if anyone had discussed their concerns about the wall or the space R1, R2 and R3 resided. NHA A stated all families were understanding and we are supporting them through this transition. R1, R2, and R3 have a history of resident-to-resident incidents, in effort to decrease the number of resident-to-resident incidents the facility relocated R1, R2 and R3 to a different location within the facility. The facility then erected an approximately six-foot wall and affixed the wall with brackets to the cement wall. This wall involuntarily secluded R1, R2, and R3 from the rest of the building and did not afford R1, R2, or R3 the same liberties and rights as all other residents in the facility. R1, R2, and R3 are not able to attend group activities or participate in other day to day activities in the facility. A reasonable person would be fearful, anxious, and feel dehumanized, when not afforded the individuality, compassion, and civility as others who reside at the facility.

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	10/09/2024

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33166 Based on interview and record review, the facility failed to notify the Office of the State Long-Term Care Ombudsman of a facility-initiated discharge, failed to ensure the written notice contained all pertinent information for a discharge notice including the location to which the resident is transferred or discharged ; a statement of the resident's appeal rights, and the name and address of the Office of the State Long-Term Care Ombudsman for 2 of 2 facility-initiated discharges reviewed involving 2 Resident (R1 and R2). R1 and R2 received involuntary discharge notices; however, the notices did not contain all necessary information. This is evidenced by: The facility's Transfer and/or Discharge Policy revised 3/2021 states in part: (2) residents are permitted to stay in the facility, and not be transferred or discharged unless: a. The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility . (3) except as specified below, the resident and his or her representative are given thirty day advance written notice of an impending transfer or discharge from the facility. (5) The resident and representative are notified in writing of the following information: a. the specific reason for transfer or discharge; b. the effective date of transfer or discharge; c. the location to which the resident is transferred or discharged ; d. an explanation of the resident's right to appeal the transfer or discharge to the state, including; (1) the name, address (mailing and email), and telephone number of the entity which receives such requests; (2) information on how to obtain, complete, and submit an appeal request; and how to get assistance completing the appeal process; f. the name, address, email and telephone number of the Office of the State Long-Term Care Ombudsman; i. the name, address, and telephone number of the state health department agency that has been designated to handle appeals of transfers and discharge notices. 6. A copy of the notice is to be sent to the Office of the State Long-Term Care Ombudsman at the same time the notice of transfer or discharge is provided to the resident and representative. 7. Residents have the right to appeal a facility-initiated discharge or discharge through a state agency that handles appeals. A. If a resident chooses to appeal a discharge, the facility will not discharge residents while the appeal is pending. The facility posted a sign dated 9/30/24 for all staff. The sign states in part; In response to the last survey visit on 9/16/24. The only way to guarantee other residents are safe; we have issued a 30-day notice to (R1) and (R2). (R1) and (R2) will be housed in the Way unit. Not ideal but in order for us to have a chance of being cleared, this needs to happen. Example 1 R1 was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease, seizure disorder, depression, and insomnia. (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	10/09/2024

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Quarterly Minimum Data Set (MDS) dated [DATE] indicates R1 has a Brief Interview for Mental Status (BIMS) of 0 out of 15, indicating R1 is severely cognitively impaired. Section E indicates that out of the last 7 days R1 has behavioral symptoms toward others 1-3 days, Verbal Symptoms toward others 1-3 days, behavioral symptoms not directed toward other 1-3 days, rejection of care 1-3 days, and wanders 1-3 days. Impact to resident and other residents is blank. Section GG indicates R1 is dependent for toileting hygiene, showers, upper and lower body dressing, and personal hygiene. On 10/2/24, the facility issued R1's family a document titled Facility-Initiated Discharge which states in part; this is to notify you of an upcoming move and your rights. Date written notice mailed/Given: 10/2/24. Resident Representative Name: FM S (Family Member/legal name). You will be moved from: (Facility Name). To: To be determined. The expected move date/time is: 11/7/24. The purpose of the move: Under CFR (s): 483:14 (C) (1) Facility requirements-(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless, the facility entered, unable to safely care for resident. (Facility Name) understands that moving can be a big change for some individuals, and every care is taken in making the right decision for all our residents. However, you do have the right to contest this decision and contact your local ombudsman about this move. The Ombudsman Contact Information is Email: BOALTC@wisconsin.gov. Phone: [PHONE NUMBER]. Staff Certifying resident/resident representative understanding prior to discharge: Name Printed: FM S signed the document. Signature: FM S Date copy of notice sent to Ombudsman: 10/2/24. Of note the above document does not contain the following: A copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. Although the document states it was sent to the Ombudsman, interview with the Ombudsman states the BOALTC (Board on Aging and Long-term Care) office did not receive the notice. The location to which the resident is transferred or discharged ; a statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; the name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman. (Emphasis intended). R1's progress notes state the following: 10/2/2024 14:41 (2:41 PM) Meeting this date with resident's husband to discuss that placement is needed in a more dementia specific placement due to unable to meet her needs safely. 30-day notice given this date including ombudsman contact information. (Resident Husband) requests that transfer plans be completed with (R1's) daughter (daughter's name). 10/2/2024 15:47 (3:47 PM) Facility initiated room change form and facility-initiated discharge notices were emailed to (Ombudsman Name) this date. 10/2/2024 15:48 (3:48 PM) This writer spoke with resident's daughters per phone to discuss 30-day notice and what facilities they would like contacted for placement. Facility that (daughter's name) works at does not have dementia care. (Daughter's name) will investigate facilities in [NAME] County so referrals can be made. Placement needs to accept medical assistance for payment. 10/4/2024 13:22 (1:22 PM) Epic sent to Dr. (name) (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	10/09/2024

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	I am writing to inform you about an important development regarding resident, who has been under our care at (facility name). After careful evaluation, we have determined that she will be receiving a facility-initiated 30-day discharge notice due to a lack of appropriateness for skilled nursing care. Throughout resident's stay, our interdisciplinary team has closely monitored her clinical needs and progress. While we have made every effort to provide the necessary support, it has become increasingly evident that she no longer meets the criteria for skilled nursing facility placement. This decision was reached based on observations and assessments which indicate that she would be better served in a different care setting such as an Alzheimer's/Dementia facility. We are committed to ensuring a smooth transition for resident. During the 30-day notice period, we will work collaboratively with you, resident's case worker, the resident, and any involved family members to develop a comprehensive discharge plan that prioritizes her health and well-being. Please let us know if you have any questions or concerns about this decision or if you would like to discuss potential options for next steps. Could you please write a discharge order and statement of support of this plan? On 10/8/24 at 8:12 PM, Surveyor interviewed FM J (Family Member) regarding R1's 30-day FID (Facility-Initiated Discharge). FM J stated on 10/2/24, FM J and her sister were looped into a meeting with SW R (Social Worker) and FM S. SW R told us a 30-day notice was being given to (R1) due to her aggression and going into other residents' rooms. The facility felt (R1) would be better off if she was on a memory care unit. This was a huge shock, we understand R1 has confusion with her dementia and wanders. We were just shocked they were making us find another place for (R1). We were told it was our responsibility to find a suitable place for (R1). Surveyor asked FM J if she or FM S received a written notice. FM J stated FM S has the written notice. Surveyor asked if the written notice contained information on how to appeal the 30-day notice? FM J stated she did not think there was any information regarding appeal rights or how to appeal the FID/30-day IVDN (involuntary discharge notice). FM J stated no one discussed that the family had the right to appeal. FM J stated this is just so hard and devastating, FM S visits (R1) every day, if we have to move (R1) FM S will not be able to visit her daily. FM J stated everyone knows moving a person with dementia can be so devastating to them and their quality of life, I just don't understand this, I thought all nursing homes cared for residents with dementia. FM J stated have you looked at the facility website, they advertise they have a Dementia Stabilization Unit, I know this is not part of the nursing home, but they have this unit and can care for dementia residents, but they can't in the nursing home; it doesn't make sense. On 10/9/24 at 8:35 AM, Surveyor interviewed SW R (Social Worker) regarding the 30-day IVDN for R1. Surveyor asked SW R what she knew regarding the 30-day notice for R1. SW R stated R1 was involved in multiple resident-to-resident incidents, R1 had 1:1 staffing on the previous unit and even with the individualized staffing R1 was ambulatory and fast enough to still have incidents with other residents. Surveyor asked SW R if she was involved in creating and giving the 30-day IVDN; SW R stated the IDT (Interdisciplinary Team) met to discuss R1 and it was agreed upon that R1 would need a 30-day IVDN. SW R stated the IVDN was being given with hopes R1 could be discharged to a dementia specific placement and smaller environment. SW R stated she met with R1's husband, and via phone with R1's daughters to discuss the 30-day discharge. SW R stated R1's husband did ask that we get R1's daughter involved as he stated he was not young and R1 should be discharged closer to where the daughters live. SW R stated she met with R1's husband at least once after the call as R1's husband was concerned R1 would be kicked out of the facility. Surveyor asked SW R who is making discharge arrangements for R1? SW R stated the facility would assist but R1's daughter was interested in assisting with the arrangements. (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	10/09/2024

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/9/24 at 10:00 AM, Surveyor met with FM S and FM J. FM S stated he was upset about (R1) receiving the discharge notice. FM S began to get tearful and stated I feel like I failed (R1) I just can't take care of her. FM S stated I visit her every day; I will not be able to do that if she moves. Can they just kick her out, what if she goes somewhere else can they give us a 30-day notice then where will she go. Surveyor interviewed NHA A (Nursing Home Administrator) regarding the 30-day IVDN for R1. NHA A stated she made the decision to give the 30-day IVDN as R1 is stable and no longer in need of skilled nursing care. NHA A stated R1 wants to touch people, she worked here, and it is very difficult for her adjusting to not working here. Surveyor asked NHA A who crafted the 30-day IVDN? NHA A stated she went line by line with the regulation when preparing the document. Surveyor asked NHA A did the 30-day IVDN include where the resident would be discharged to, the resident's appeal rights, including the name, address (mailing and email), and telephone number for DQA and the Regional Director, information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; the name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman. NHA A stated, I followed the regulation, and the information was on the form for the Ombudsman, and we did send it. On 10/9/24 at 9:15 AM, Surveyor spoke with Ombudsman C. Ombudsman C indicated she did not receive notice of R1 and R2's 30-day involuntary discharge notices. Ombudsman C indicated she received an email from SW R (Social Worker) on 9/27/24 around 4:41PM indicating they had 2 dementia residents that SW R issued notice of a move to another hall. Ombudsman C indicated she did not receive correspondence on which hall or where the residents were moved to. Ombudsman C indicated she received a call from SW R on 10/1 regarding residents not being qualified for the DSU (Dementia Stabilization Unit) and was asking for assistance. Ombudsman C indicated she referred them to the Alzheimer's Association for ideas. Example 2 R2 was admitted on [DATE] with diagnoses that include Alzheimer's, dementia, muscle weakness, and unsteadiness on feet. R2's Quarterly Minimum Data Set (MDS) dated [DATE] indicates R2 has a Brief Interview for Mental Status (BIMS) of 0 out of 15, indicating R2 is severely cognitively impaired. Section B indicates R2 hears adequately, has clear speech, usually makes self-understood, and usually understands others. Section E indicates that R2 has not had rejection of cares, physical, verbal, or other behavioral symptoms, or wandering in the last 7 days. Impact to Resident and other residents is blank. Section GG indicates R2 needs supervision or touching assistance with toileting hygiene, showers, lower body dressing, and personal hygiene. R2 is independent with sitting to lying, lying to sitting, sitting to standing and transferring from chair to bed or bed to chair, toileting, and walking. (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	10/09/2024

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/2/24, the facility issued R2's family a document titled Facility-Initiated Discharge which states in part; this is to notify you of an upcoming move and your rights. Date written notice mailed/Given: 10/2/24. Resident Representative Name: FM K (Family Member/legal name). You will be moved from: (Facility Name). To: To be determined. The expected move date/time is: 11/7/24. The purpose of the move: Under CFR (s): 483:14 (C) (1) Facility requirements-(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless, the facility entered, unable to safely care for resident. (Facility Name) understands that moving can be a big change for some individuals, and every care is taken in making the right decision for all our residents. However, you do have the right to contest this decision and contact your local ombudsman about this move. The Ombudsman Contact Information is Email: BOALTC@wisconsin.gov. Phone: [PHONE NUMBER]. Staff Certifying resident/resident representative understanding prior to discharge: Name Printed: FM K signed the document. Signature: FM K Date copy of notice sent to Ombudsman: 10/2/26. Of note the above document does not contain the following: A copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. Although the document states it was sent to the Ombudsman, interview with the Ombudsman states the BOALTC (Board on Aging and Long-term Care) office did not receive the notice. The location to which the resident is transferred or discharged ; a statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; the name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman. (Emphasis intended). Progress notes dated Facility-initiated Room Transfer, states in part: Resident name: (R2). Date written Notice Given or mailed (circle one): 9-27-24 per phone. Resident Representative Name (if applicable): (FM K (Family Member)). This is to notify you of an upcoming move within the facility to another room within the facility. You will be moved from: Room number (number) on View unit to Room Number (number) on way unit. The expected move date/time is: 9-30-24. Date, (time is blank).The purpose of the move: Smaller unit to control behaviors affecting others and allow wandering . Progress notes dated 10/4/2024 13:23 (1:23PM) Epic sent to Dr. (name) I am writing to inform you about an important development regarding resident, who has been under our care at (facility name). After careful evaluation, we have determined that she will be receiving a facility-initiated 30-day discharge notice due to a lack of appropriateness for skilled nursing care. Throughout resident's stay, our interdisciplinary team has closely monitored her clinical needs and progress. While we have made every effort to provide the necessary support, it has become increasingly evident that she no longer meets the criteria for skilled nursing facility placement. This decision was reached based on observations and assessments which indicate that she would be better served in a different care setting such as an Alzheimer's/Dementia facility. We are committed to ensuring a smooth transition for resident. During the 30-day notice period, we will work collaboratively with you, resident's case worker, the resident, and any involved family members to develop a comprehensive discharge plan that prioritizes her health and well-being. (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	10/09/2024

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Please let us know if you have any questions or concerns about this decision or if you would like to discuss potential options for next steps. Could you please write a discharge order and statement of support of this plan? On 10/9/24 at 8:55 AM, Surveyor interviewed FM K (Family Member) regarding R2's 30-day FID (Facility-Initiated Discharge). FM K stated on 10/1/24, FM K had a meeting with the SW R (Social Worker), SW R stated they were moving (R2) elsewhere, and a 30-day involuntary discharge notice (IVDN) was being given to (R2). FM K stated she was told they reason for the 30-day IVDN was because (R2) was causing the facility to receive too many citations. FM K stated I was so upset; I could not believe this was happening. FM K stated I know (R2) touches people and then (R2) will get hit or R2 will want to hug someone, and the other person does not like it and then there is slaps exchanged. FM K stated the facility told her they were doing 1:1 with (R2) and it was not working, I never saw staff doing 1:1 and I am here a lot. FM K stated the facility stated (R2) would be better off if she was on a memory care unit. I was beside myself and just completely shocked to hear they were making us find another placement for (R2). Surveyor asked FM K if she received a written notice. FM K stated she has the written notice. Surveyor asked if the written notice contained information on how to appeal the 30-day notice? FM K stated she did not think there was any information regarding appeal rights or how to appeal the FID/30-day IVDN. FM K stated no one discussed that the family had the right to appeal. FM K stated what nursing home doesn't care for a resident with dementia, this just does not seem right to me. On 10/9/24 at 8:35 AM, Surveyor interviewed SW R (Social Worker) regarding the 30-day IVDN for R2. Surveyor asked SW R what she knew regarding the 30-day notice for R2. SW R stated R2 was involved in multiple resident-to-resident incidents, R2 had 1:1 staffing on the previous unit and even with the individualized staffing R2 was ambulatory and fast enough to still have incidents with other residents. Surveyor asked SW R if she was involved in creating and giving the 30-day IVDN? SW R stated the IDT (Interdisciplinary Team) met to discuss R2 and it was agreed upon that R2 would need a 30-day IVDN. SW R stated the IVDN was being given with hopes R2 could be discharged to a dementia specific placement and smaller environment. SW R stated she met with R2's daughter to discuss the 30-day discharge. Surveyor asked SW R who is making discharge arrangements for R2? SW R stated the facility will assist and work with R2's managed care organization. Surveyor interviewed NHA A (Nursing Home Administrator) regarding the 30-day IVDN for R2. NHA A stated she made the decision to give the 30-day IVDN as R2 is stable and no longer in need of skilled nursing care. NHA A stated R2 has been here a long time and the amount of supervision needed would be very restrictive for R2. Surveyor asked NHA A who crafted the 30-day IVDN? NHA A stated she went line by line with the regulation when preparing the document. Surveyor asked NHA A did the 30-day IVDN include where the resident would be discharged to, the resident's appeal rights, including the name, address (mailing and email), and telephone number for DQA and the Regional Director, information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; the name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman. NHA A stated I followed the regulation, and the information was on the form for the Ombudsman, and we did send it. (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	10/09/2024

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/9/24 at 9:15 AM, Surveyor spoke with Ombudsman C. Ombudsman C indicated she did not receive notice of R1 and R2's 30-day involuntary discharge notices. Ombudsman C indicated she received an email from SW R (Social Worker) on 9/27/24 around 4:41 PM indicating they had 2 dementia residents that SW R issued notice of a move to another hall. Ombudsman C indicated she did not receive correspondence on which hall or where the residents were moved to. Ombudsman C indicated she received a call from SW R on 10/1/24 regarding residents not being qualified for the DSU (Dementia Stabilization Unit) and asking for assistance. Ombudsman C indicated she referred them to the Alzheimer's Association for ideas.

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	10/09/2024

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36192 Based on observation, interview, and record review, the facility failed to provide an ongoing program to support resident choice of activities, based on the comprehensive assessment and care plan and the preferences of each resident for 3 of 3 Residents (R1, R2, R3) residing on the Way Unit. Activity staff and staff working on the Way Unit were not providing or offering activities for R1, R2, and R3. There is no documentation of R1, R2, and R3 participating or being offered activities since they were moved to the Way Unit. This is evidenced by: Facility Policy entitled 'Individual Activities and Room Visit program,' states in part: .Individual activities will be provided for those residents whose situation or condition prevents participation in other types of activities and for those residents who do not wish to attend group activities. Residents who are able to maintain an independent program will have supplies available to them.1. individual activities are provided for individuals who have conditions or situations that prevent them from participating in group activities, or who do not wish to do so. 2. For those residents whose condition or situation prevents participation in group activities, and for those who do not wish to participate in group activities, staff provides individualized activities consistent with the overall goals of an effective activities program. 3. Individualized activities offered are reflective of the resident's comprehensive care plan. 4. it is recommended that residents with in-room activity programs receive, at a minimum, three in -room visits per week. A typical in-room visit is ten to fifteen minutes in length but may be longer if appropriate for the resident. 5. Activities for residents with behavioral or emotional problems who cannot participate in group activities include: a. uncomplicated activities that can be adapted to the level of the individual's attention span and function; b. activities requiring short periods of concentration to reduce frustration; and c. activities tailored to address specific underlying causes of the individuals behavioral or attention limitations (e.g.; familiar occupation-related activities, exercise and movement activities, engaging the resident in conversation, and using one-to-one activities such as looking at familiar pictures and photo albums). 6. Residents who choose not to attend group activities are encouraged to participate in independent activities. It is the responsibility of the facility and the activity staff to make regular contact with residents who choose to pursue independent activities, maintain appropriate records and offer supplies, as needed. Example 1 R1 was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease, Seizure disorder, Depression, and Insomnia. R1's Quarterly Minimum Data Set (MDS) dated [DATE] indicates R1 has a Brief Interview of Mental Status (BIMS) of 0 out of 15, indicating R1 is severely cognitively impaired Section E indicates that out of the last 7 days R1 has behavioral symptoms toward others 1-3 days, Verbal Symptoms toward others 1-3 days, behavioral symptoms not directed toward other 1-3 days, rejection of care 1-3 days and wanders 1-3 days. Impact to Resident and other residents is blank. Section GG indicates R1 is dependent for toileting hygiene, showers, upper and lower body dressing, and personal hygiene. (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	10/09/2024

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Activity Care Plan, states in part: I am dependent on staff for meeting emotional, intellectual, physical and social needs r/t (related to) dementia and cognitive deficits . Goal: I will maintain involvement in cognitive stimulation, social activities as desired through review date .Interventions/Tasks: All staff to converse with me while providing care .Establish and record my prior level of activity involvement and interests by talking with me, caregivers, and family on admission and as necessary. Read my background sheet with my history . I need assistance with ADL's as required during the activity .I needs [sic] assistance/escort to activity functions . I prefer activities which do not involve overly demanding cognitive tasks. Engage in simple, structured activities such as music, crafts, baking .introduce me to residents with similar background, interests and encourage/facilitate interaction .invite the me [sic] to scheduled activities .my preferred activities are: Crafts, baking, laundry, music, old movies, old shows [NAME] and Waltons, watching sports (basketball and football), casino games, cats and dogs .Provide a program of activities that is of interest and empowers me by encouraging/allowing choice, self-expression and responsibility. I was a caregiver and enjoy helping others .Provide me with materials for individual activities as desired. I like the following independent activities. Combining material pieces into a quilt pattern, sorting items, creating a design .when I choose not to participate in organized activities, I prefers [sic] to visit for social and sensory stimulations . On 10/9/24, during record review, Surveyor was unable to locate documentation of activity attendance or declination, in R1's Record. Example 2 R2 was admitted on [DATE] with diagnoses that include Alzheimer's, restless leg syndrome, Dementia, muscle weakness, and unsteadiness on feet. R2's Quarterly Minimum Data Set (MDS) dated [DATE] indicates R2 has a Brief Interview of Mental Status (BIMS) of 0 out of 15, indicating R2 is severely cognitively impaired. Section B indicates R2 hears adequately, has clear speech, usually makes self-understood, and usually understands others. Section E indicates that R2 has not had rejection of cares, physical, verbal, or other behavioral symptoms, or wandering in the last 7 days. Impact to Resident and other residents is blank. Section GG indicates R2 needs supervision or touching assistance with toileting hygiene, showers, lower body dressing and personal hygiene. R2 is independent with sitting to lying, lying to sitting, sitting to standing and transferring from chair to bed or bed to chair, toileting, and walking. R2's Activity Care plan states in part: I have impaired cognitive function/dementia or impaired thought process r/t (related to) dementia .Goal: I will maintain current level of decision making ability by choosing my meals, clothing and bedtime by review date .I will be able to communicate basic needs on a daily basis through the review date . interventions/tasks: .engage me in simple, structured activities that avoid overly demanding tasks. I prefer to fold towel and napkins and sorting items like buttons (4/4/23). I need assistance with all decision making . Present just one thought, idea, question, or command at a time . provide a program of activities that accommodates my abilities .provide me with a homelike environment: likes to talk about her quilts she made, and her pictures of family on bulletin board .Reminisce with me using photos of family and friends . On 10/9/24, during record review, Surveyor was unable to locate documentation of activity attendance or declination, in R2's Record. (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	10/09/2024

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Example 3 R3 was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease, chronic pain, delusional disorders, major depression, anxiety, and adjustment disorder. R3's Quarterly Minimum Data Set (MDS) dated [DATE] indicates R3 has a Brief Interview of Mental Status (BIMS) of 0 out of 15, indicating R3 is severely cognitively impaired Section E indicates that out of the last 7 days 1-3 days, behavioral symptoms not directed toward other. Section GG indicates R3 is supervision/maximum assistance for toileting hygiene, showers, dressing, and personal hygiene. R3's Activity Care plan states in part: I am dependent on staff for meeting emotional, intellectual, physical, and social needs r/t (related to) Advanced Alzheimer's. (date initiated: 2/28/23, revision on: 9/6/24). Goal: I will attend/participate in activities as able through review date as I have advanced Alzheimer .target date 12/10/2024.Interventions/tasks: All staff to converse with me while providing care (2/28/23). Encourage ongoing family involvement. invite my family to attend special events, activities, meals .I needs [sic] assistance/escort to activity functions .I prefer activities which do not involve overly demanding cognitive tasks. Engage in simple, structured activities (Revision 9/6/24) .Invite the me [sic] to scheduled activities. I may not stay at activities long as I have advanced Alzheimer and inattention. I like to be moving. (Revision 9/6/24). My preferred activities are 1:1, sitting in the common area with groups of people, listening to music, walking with a staff member, rolling a yarn ball, caring for baby doll. I also enjoy having snacks and drinks between meals. I like comfort care from the staff such as warm blankets, hand holding, massages. I enjoy when my family comes to visit. (revision 9/6/24). R3's Activities - Quarterly/annual participation review form indicates: Attendance and participation summary. 1. Described the residents attendance preferences and participation [sic] level with activities (group, event, 1:1). Resident does not attend many activities. Staff tries to bring her to them, but she usually leaves. Activity plan review: Describe changes to interventions/approaches: We're trying to do new activities and approaches [sic] with resident. On 10/9/24, during record review, Surveyor was unable to locate documentation of activity attendance or declination, in R3's record. On 10/9/24 at 8:40 AM, Surveyor interviewed ACT F (Activity Staff) regarding the way unit. ACT F indicated R1, R2, and R3 were moved for the safety of other residents. ACT F indicated she has not been on the unit other than she (ACT F) took down activities for them to do such as sensory items, puzzles, coloring items, and a large balloon ball. ACT F is unaware if someone is doing activities with them on the unit and to ask ACT G. On 10/9/24 at 8:44 AM, Surveyor interviewed ACT G regarding activities for R1, R2, and R3. ACT G indicated she is the Life Enrichment Director. ACT G indicated they have coloring, music, Lego's, puzzles, and items to keep their hands busy down on the unit available. Surveyor asked ACT G if anyone from activities is doing activities with R1, R2, and R3 on that unit, ACT G stated, No. ACT G indicated she was told they're not responsible for activities on the way unit, and she can only assume the CNAs are doing activities with them. ACT G indicated they do an activity from 10 AM to 11 AM and 2 PM to 3 PM on other units each day. Surveyor asked ACT G who would be documenting participation of activities or if they were offered for R1, R2, and R3. ACT G indicated she was not aware if the CNAs were told they are to do activities with the residents or if they are documenting it. (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	10/09/2024

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/9/24 at 9:00 AM, Surveyor interviewed CNA V regarding the way unit. Surveyor asked about activities and CNA V indicate she was not sure if they're being done or if doing 1:1 like upstairs. (Of note: R1, R2, and R3 were previously on a unit that offered 1:1 with residents.) On 10/9/24 at 8:56 AM, Surveyor interviewed RA/CNA Q (Resident Assistant/Certified Nursing Assistant) about activities on the unit. RA Q indicated staff do some activities like coloring. RA Q indicated she is not aware of any activity staff coming down to the unit. RA Q indicated that R2 will color with staff, R1 will listen to music in her room and R3 is more 1:1 as she's up and down a lot. RA Q indicated she's alone on the unit and the nurse comes with medications and when needed. RA Q indicated she is not able to do 1:1 activity with all three Residents. On 10/9/24 at 10:20 AM, Surveyor interviewed NHA A (Nursing Home Administrator). Surveyor asked NHA A if activity staff are doing activities on the unit, NHA A indicated they are. Surveyor asked for activity documentation prior to today (10/9/24) for R1, R2, and R3. On 10/9/24 at 4:15 PM, Surveyor interviewed RA H regarding the way unit. RA H indicated she works the way unit and works three times per week. RA H stated, I'm just an RA, I can't do physical care, and indicated she has access to a unit phone. RA H indicated she passes out the meals and does 15-minute checks on R1, R2, and R3. Surveyor asked RA H about activities, RA H indicated during the day shift they (R1, R2, and R3) usually sleep and that RA H hasn't done activities with them. RA H indicated she was not sure if anyone does activities with them. RA H indicated she leaves at 3pm On 10/9/24 at 6:24 PM, Surveyor interviewed BOM Z (Business Office Manager), who over sees the activity department. Surveyor asked BOM Z if there is documentation of activities being offered, declined or how much R1, R2, and R3 participated in the activity, BOM Z indicated that staff chart under a progress note in the computer under activities. Surveyor brought up R1, R2, R3's notes. No daily documentation was documented from 10/1 to current. BOM Z indicated in the last 6 weeks or so staff started putting notes in regarding 1:1, if any concerns are expressed or if it was a good visit etc., Surveyor asked what staff are to do if a resident declines/refuses an activity, BOM Z indicated document it. BOM Z indicated they had three activity staff working daily. BOM Z indicated the activity calendar is put together based on resident input. Surveyor asked if R1, R2, and R3 are offered the same activities as the other residents, BOM Z indicated they don't sit down and participate as they're antsy. BOM Z indicated that ACT F brought items down. BOM Z indicated she is not sure if CNA's document activities being provided or if they're aware how to document activity participation. On 10/9/24 at 6:45 PM, Surveyor asked NHA A again for documentation for activity participation or documentation that activities are being offered to R1, R2, and R3 from 10/1/24 to current. Two staff statements dated 10/9/24 were provided to Surveyor indicating the following: Employee CNA N, I provided the following activities with R3, R2, and R1: I walked with R3, R1 and I colored together; I walked with R2 and colored with her. Signature: verbal statement obtained from CNA N on 10/9/24 at 10:30 (am) date: 10/9/24, signed by DON B (Director of Nursing) (of note the statement does not indicate what day or shift this occurred, and it was not documented in their medical record) (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	10/09/2024

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff statement: Employee: CNA Y, I provided the following activities with R3, R2, and R1 on 10/4/24 night shift: R3 went to the bathroom and slept all night. R1 slept all night; I walked with R2 and watched the movie Friday with her. (Of note: no documentation was provided from 10/1/24 to 10/9/24 to show R1, R2, and R3 are receiving activities daily or if they did/did not participate in the activity that was offered or if 1:1 activity was provided.)

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	10/09/2024

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 36192 Based on interview and record review, the facility failed to assure that there is sufficient, qualified nursing staff available at all times to provide nursing and related services to meet the residents' needs safely and in a manner that promotes each resident's rights, physical, mental, and psychosocial well-being for 3 of 3 Residents (R1, R2, & R3). RA (Resident Assistants), who are not Certified Nursing Assistants, were working on the Way Unit alone with R1, R2 and R3 who require increased supervision. This is evidenced by: Facility Employee list shows RA H, RA CC, RA X, and RA AA as being RA's and CNA (Certified Nursing Assistant) Facility staffing schedule indicates the following: On 10/1/24, RA H worked 6:30 AM to 3:00 PM, on the Way Unit and RA CC worked the Way Unit from 3:00 PM to 4:00 PM with another RA training. On 10/2/24, RA CC worked 1:30 PM to 10:00 PM on the Way Unit. No indication on the schedule of a CNA being assigned to the Way Unit during this time. On 10/5/24, RA H worked from 6:30 AM to 3:00 PM, no indication on the schedule who was assigned to the Way Unit or if a CNA worked on the Way Unit during this time. (Per RA H's interview RA H worked on the Way Unit on 10/5/24). RA X and RA AA (training) worked 2:30 PM to 7:00 PM indicated as being on the Way Unit. On 10/6/24, RA H worked 6:30 AM to 3:00 PM, per the schedule on the Way Unit. RA X worked 2:30 PM to 9:00 PM on the Way Unit while training RA AA who worked 2:30 PM to 11:00 PM. No indication on the schedule of a CNA being assigned to the Way Unit during that time. On 10/7/24, RA H worked on the Way Unit from 6:30 AM to 3:00 PM, no indication on the schedule of CNA working the Way Unit during that time. Way is hand written next to RA H's time on the schedule. On 10/9/24 at 8:55 AM, Surveyor interviewed FM K (Family Member) regarding the Way Unit. FM K indicated RA H worked alone on the unit on Saturday (10/5) and Sunday (10/6). FM K indicated other RA's have also worked alone on the Way Unit. (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	10/09/2024

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/9/24 at 10:20 AM, Surveyor interviewed NHA A (Nursing Home Administrator). Surveyor asked NHA A for RA H, RA X, and RA AA's CNA registry as of today. NHA A indicated those three are not CNA's. Surveyor asked how RA's get help on the unit, NHA A indicated they have a phone and call the View Unit for assistance. NHA A indicated just this week they have a full time CNA on the unit for safety reasons. NHA A indicated RAs are not able to do hands on care. Surveyor asked if one the residents on the Way Unit were falling or had an emergency could the RA help them, NHA A indicated no. NHA A indicated there are no RAs on that unit now. On 10/9/24 at 4:15 PM, Surveyor interviewed RA H regarding the Way Unit. RA H indicated she works the Way Unit and works three times per week. RA H stated, I'm just an RA, I cannot do physical care, RA H indicated she had access to a unit phone to get assistance if needed. RA H indicated she passes out the meals and does 15-minute checks on R1, R2 and R3. RA H indicated she cannot put her hands on the residents but would try to reroute them or try to distract them if an incident were to occur. RA H indicated when all three residents (R1, R2, and R3) are awake they need to be line of sight and that RA H is only one person and doesn't feel it's safe to have just one person/RA on the Way Unit. RA H indicated they keep the double doors shut and alarms on R1, R2 and R3's bedroom doors. RA H indicated she would prefer a CNA to be down on the unit so there are 2 people. RA H indicated that the View nurse came down Saturday (10/5) and on Sunday (10/6), R2 became physical and verbal towards her. RA H indicated she called the nurse for help, and no one answered the phone. Surveyor asked RA H if she's received training on dementia care or behaviors, RA H indicated no. RA H indicated they are short of staff, and she feels management is testing the waters on RA's being alone on the unit. RA H indicated she was to be done at 3:00 PM; however, there was not a designated person to cover the unit on Sunday or Monday as they didn't have coverage. RA H expressed that if there is only one person on the unit and that person is in a room, who's watching the other two residents. Calls placed to RA X and RA AA; Surveyor was unable to reach them for an interview. The facility is not ensuring a Certified Nursing Assistant is assigned each shift to provide cares for R1, R2, and R3.

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	10/09/2024

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 36192 Based on observation and interview, the facility did not maintain a safe and sanitary environment in which food is prepared, stored, and distributed. This has the potential to affect all 64 Residents who reside in the facility. Kitchen floor was unclean with visible dirt and food debris on the floor. Dish machine rinse temperature did not reach the 180-degree rinse requirement. Evidenced by: Facility Policy titled 'Sanitization,' states in part: .The food service area shall be maintained in a clean and sanitary manner . 1. All kitchens, kitchen areas and dining areas shall be kept clean, free from litter and rubbish and protected from rodents, roaches, flies, and other insects. 4. Sanitizing of environmental surfaces must be performed with one of the following solutions: a. 50-11 ppm chlorine solution; 150-200ppm quaternary ammonium compound (QAC); or c. 12.5ppm iodine solution.15. Kitchen and dining room surfaces not in contact with food shall be cleaned on a regular schedule and frequently enough to prevent accumulation of grime. 16. the food services manager will be responsible for scheduling staff for regular cleaning of kitchen and dining areas. Food service staff will be trained to maintain cleanliness throughout their work areas during all tasks, and to clean after each task before proceeding to the next assignment. Facility policy titled 'Dishwashing Machine Use,' states in part: .2 Dishwashing machines that use hot water to sanitize must maintain the following wash solution temperatures: a. 150 F (degrees Fahrenheit) for stationary rack, dual temperature machines or multi-tank, conveyor, multi-temperature machines. b. 160 F (degrees Fahrenheit) for single tank, conveyor, dual temperature machines. c. 165 F for stationary rack, single temperature machines. d. if the temperature for the rinse is under 150 F, all dishes are to be washed twice. 3. Dishwashing machine hot water sanitation rinse temperatures may not be more than 194 F, or less than: a. 165 F for stationary rack, single temperature machines. b. 180 F for all other machines.7.The operator will check temperatures using the machine gauge with each dishwashing machine cycle and will record the results in a facility approved log. The operator will monitor the gauge frequently during dishwashing machine cycle. Inadequate temperatures will be reported to the supervisor and corrected immediately.9. If hot water temperatures or chemical sanitation concentrations do not meet requirements, cease use of dishwashing machine immediately until temperatures or PPM are adjusted. Manufacturer information, titled Technical Data High Temp Rinse, indicates in part: Directions for use: Final Rinse temperature should be maintained as close to the 180 degrees Fahrenheit minimum as possible, and should not exceed 190 degrees, in any case. October 2024 Sanitizer test log indicates the following: 10/3 AM shift is blank indicating the sanitizer was not tested (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	10/09/2024

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	10/5 AM shift is blank indicating the sanitizer was not tested 10/6 AM shift is blank indicating the sanitizer was not tested 10/7 PM shift is blank indicating the sanitizer was not tested 10/8 PM shift is blank indicating the sanitizer was not tested October 2024 Dishwasher temp log indicates the following: 10/1 10:00 am Final rinse was 152 degrees, internal disk temp was 144.1, corrective action ran two times. PM (evening) final rinse was 156 degrees and internal disk temp 145.7, corrective action ran twice. 10/2 11:00 am Final rinse was 151.2 degrees, internal disk temp was 148.2, corrective action ran two times. PM (evening) final rinse was 156 degrees and internal disk temp 140, corrective action ran twice. 10/3 10:00 am Final rinse was 140.7 degrees, internal disk temp was 145, corrective action ran two times. PM (evening) final rinse was 159 degrees and internal disk temp 144, corrective action ran twice. 10/4 9:47 am Final rinse was 147 degrees, internal disk temp was 146.8, corrective action ran two times. PM (evening) final rinse was 136 degrees and internal disk temp 149, corrective action ran twice. 10/5 for day shift it's blank. PM (evening) final rinse was 159 degrees and internal disk temp 147, corrective action ran twice. 10/6 for day shift it's blank. PM (evening) final rinse was 149 degrees and internal disk temp 146, corrective action ran twice. 10/7 10:00 am Final rinse was 151 degrees, internal disk temp was 150.8, corrective action ran two times. PM is blank. 10/8 10:00 am Final rinse was 149 degrees, internal disk temp was 150.4, corrective action ran two times. PM is blank. On 10/9/24 at 6:44 AM, Surveyor observed the Kitchen with DA I (Dietary Aide). DA I indicated the kitchen is mopped and swept on Tuesdays and Thursdays. Surveyor observed the kitchen floor to have brownish black areas all over the floor along with food debris under prep stations, oven, three compartment sink and warming carts. The tile flooring near the drain had cracks in the tiles and a gouge in the tile near the dishwashing room door. DA I indicated the floors are not clean. (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	10/09/2024

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 10/9/24 at 7:04 AM, Surveyor interviewed DA E regarding the dish machine. DA E indicated the dish machine has a problem with filling and doesn't want to work right away. DA E indicated they test the temperatures in the middle after two carts go in. DA E indicated they use a temp disk in the middle of the rack. DA E indicated they have been running the dishes twice due to not reaching temperature. Surveyor observed the temperature log with DA E, and DA E indicated No, when Surveyor asked if the Dish machine was temping to 180 degrees for a rinse temp. DA E indicated the dish machine issue has been going on for about two weeks or so and maintenance is aware. DA E indicated they need more dietary staff, and the floors need to be cleaned more often. Surveyor observed the dish room floor to be dirty with brown and black discolored areas and debris. On 7/10/24 at 7:10 AM, Surveyor interviewed MNT T (Maintenance) regarding the dish room floor and kitchen floor. Surveyor asked MNT T if the floors looked clean, MNT T indicated the floor could be swept. On 10/9/24 at 7:40 AM, Surveyor observed the dish room, kitchen, and temperature logs with NHA A (Nursing Home Administrator). NHA A indicated based on the temperature log/form the dish machine was not temping correctly. Surveyor asked NHA A if the dishes were being sanitized properly if the dish machine temperature is not reaching the correct temperature, NHA A stated no. NHA A indicated they have had water heater issues recently. Surveyor reviewed temp log and sanitizer log noting blanks on the form, NHA A indicated the temperature log and sanitizer log are incomplete and should be completed. On 10/9/24 at 10:30 AM, Surveyor interviewed MNT U (Maintenance) regarding the water temps. MNT U indicated a boiler has been down and if the water is not 140 degrees when it hits the dish machine heat exchange, the exchange is not able to heat the water up the additional 40 degrees that is required, resulting in water temps not reaching the 180-degree rinse temperature. On 10/9/24 at 10:40 AM, Surveyor interviewed DM W regarding the dishwasher temperatures. DM W indicated they do dishes twice if the dish machine doesn't meet the 150-degree wash temperature. DM W indicated she has acknowledged that the floors haven't been getting done, usually (Staff Members Name) is here Tuesday and Thursday. DM W indicated she is working with a new staff member on deep cleaning tasks. DM W indicated if staff notice the kitchen is dirty, they should clean it.