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	01/16/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26446 Based on interview, record review, and facility policy review, the facility failed to ensure residents were free from physical abuse for three of four (Residents (R) R2, R11, and R8) residents reviewed for physical abuse. The facility failed to put consistent interventions into place to prevent one resident (R3) from repeated physical violence towards other residents. Findings include: Review of the facility's undated policy titled, Abuse, Neglect and Exploitation, revealed, It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property . Instances of abuse of all residents, irrespective of any mental or physical condition . Possible indicators of abuse include, but are not limited to . physical abuse of a resident observed . The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse . Increased supervision of the alleged victim and residents . Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all required agencies . within specified timeframes . Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. Facility provided documentation and resident record review revealed three incidents of resident-to-resident aggression with R3 as the assailant. On 11/12/24, R3 was reported to have struck out at R2; on 12/06/24, R3 was reported to have struck out at R11; and on 01/12/25, R3 was reported to have struck out at R8. Review of R3's electronic medical record (EMR) Profile tab revealed R3 was admitted to the facility on [DATE] with diagnoses of Alzheimer's disease, anxiety disorder, dementia in other diseases severe with agitation, and insomnia. (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R3's quarterly Minimum Data Set (MDS), located under the MDS tab of the EMR and with an Assessment Reference Date (ARD) of 12/17/24, revealed R3 had a Brief Interview for Mental Status (BIMS) score of 00 out of 15, which indicated significant cognitive impairment. Further review revealed R3 wandered one to three days during the assessment period, used a walker and wheelchair for mobility, and was supervision or touching assistance when walking ten feet, fifty feet with two turns, and walking 150 feet. Review of R3's Care Plan, located in the EMR under the Care Plan tab and initiated 06/17/23, revealed R3 had the potential to be physically aggressive (hitting others) related to dementia and poor impulse control. Interventions identified prior to the incidents below were, if R3 becomes agitated (targeting with her walker or yelling at other residents, visitors, staff) assign a staff member to stay with resident and intervene before agitation escalates, guide her away from source of distress, complete frequent checks throughout the day when out of her room, and an alarm on her to notify staff when she comes out into the hallway. Example 1: R3 to R2 on 11/12/24: Review of R2's Profile tab of the EMR revealed R2 was admitted to the facility on [DATE] with diagnoses of dementia, hypertension, and major depressive disorder. Review of R2's quarterly MDS, located under the MDS tab of the EMR and with an ARD of 11/19/24, revealed a BIMS score of 00 out of 15, which indicated significant cognitive impairment. Further review revealed R2 had no behaviors, did not wander, and required substantial/maximal assistance when walking ten feet, fifty feet with two turns, and walking 150 feet. Review of a facility provided Misconduct Incident Reporting, dated 11/12/24 at 2:45 PM, revealed that residents were coming back from an event down in the club 48 for a birthday bingo bash. Five residents who were all in wheelchairs were taken up to the second floor. R3 came up also and was attempting to get through the wheelchairs in the lobby to get to her unit. She used a walker and could not get around the residents' wheelchairs. R3 walked toward R2 in the chair and could not get past her. R3 used a closed fist and firmly banged R2 on the right shoulder three times to get her to move. A Certified Nursing Assistant (CNA8) saw it occurring and was walking over to help when the hit occurred. CNA8 helped support R3 around the wheelchairs so she could get to her unit and remove her from the area and have supervision on her unit. CNA8 checked on R2 and the Registered Nurse (RN) on staff checked R2 for bruising and injury. No bruising or injury were present. Staff also checked with R2 who did not remember anything happening. CNA8, who witnessed the incident, walked over immediately to help R3 get through and take her to the unit. Review of R3's Care Plan, located in the EMR under the Care Plan tab and initiated 03/12/24, revealed R3 was dependent on staff for meeting emotional, intellectual, physical, and social needs related to dementia and cognitive deficits. Interventions were revised on 11/19/24 after the incident between R3 and R2 to include providing one on one supervision when going to and from activities not on her unit. (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/16/25 at 4:33 PM, CNA8 stated that the residents were returning from an activity, and R3 wandered to where R2 and other residents were, and the area was crowded. CNA8 stated that when people are in R3's way she will ram her walker or hit people on the shoulder. She stated this was common for her when she was in a mood and would hit shoulders. Example 2: R3 to R11 on 12/06/24: Review of R11's Profile tab of the EMR revealed R11 was admitted to the facility on [DATE], with a last readmittance of 11/15/24, with diagnoses of anemia, depression, atrial fibrillation, and dysphagia. Review of R11's admission MDS, located under the MDS tab of the EMR and with an ARD of 11/19/24, revealed R11 had a BIMS score of 03 out of 15, which indicated severe cognitive impairment. Further review revealed R11 required partial/moderate assistance with mobility to walk ten feet. Review of R11's Progress Note, located under the Progress Note tab in the EMR and dated 12/06/24 at 4:52 PM, indicated R11 was .involved in a resident-to-resident incident. Resident was struck by another resident on her right arm when they weren't able to get their walker around this residents (sic) wheelchair in the hallway . No apparent injuries noted at this time. Resident is able to move her right upper extremity at baseline. Resident denies any pain at this time. Resident stated she feels safe living here at this facility . Review of the facility's Physical Aggression Initiated form, dated 12/06/24, revealed, Resident [R3] was seen walking down the hallway with her FWW (four-wheel walker). Resident came up behind another resident wheelchair [R11]. Resident was unable to maneuver her walker around the other residents (sic) wheelchair . strike resident on their arm . Resident was placed on 1:1 with designated staff . Residents agitation improved after those interventions . Immediate intervention: Staff will offer toileting and check for incontinence frequently and as needed as this is a known agitation. A written statement by Life Enrichment (LE) documented, On Friday, December 6, 2024 at 9:50 AM, I was returning two residents . from the craft fair in the community room .coming down the hall and [R3] bumped her walker into [R11] and before I could get to [R3] she struck [R11] with the side of her fist. [R3] struck [R11] in the right shoulder . I checked on [R11] to see that she was ok. She stated she was. I told her I would let staff know what occurred and she said ok . [R11] appeared fine but had an upset look on her face. The report documented that the physician and family were informed. It was not reported to the state agency or investigated. It was recorded R3 was placed on 1:1 with designated staff to ensure the safety of other residents. Review of R3's Care Plan, located in the EMR under the Care Plan tab and initiated 06/17/23, revealed R3 had the potential to be physically aggressive (hitting others) related to dementia and poor impulse control. Interventions were revised on 12/06/24 after the incident between R3 and R11 to check frequently and as needed for incontinence as that is a known trigger for agitation. (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/16/25 at 9:30 AM, the Social Services Director (SSD) stated that the incident on 12/06/24 with R3 and R11 was not abuse due to no willful intent and no concern from R11. During an additional interview at 11:00 AM, SSD stated R11 had short-term memory which was not as good as her long-term memory. She confirmed that R11 was not interviewable. She confirmed the resident-to-resident incident on 12/06/24 was witnessed by staff. During an interview on 01/16/25 at 1:40 PM, LE stated that she was coming through the double doors with two different residents and observed R11 down the hallway. She stated she observed R3 going towards R11 with her walker. She stated that R11 was in her wheelchair going to the dayroom, and R3 was going towards R11, and she observed R3 strike R11 with the back of her hand like a swipe. She stated she reported it and filled out a statement right away. LE stated she knew it needed to be reported. LE stated she figured the management was supposed to report it, and since she filled out the information, she believed they had reported. Example 3: R3 to R8 on 01/12/25: Review of R8's Profile tab of the EMR revealed R8 was admitted to the facility on [DATE] with diagnoses of anxiety, dementia, and major depressive disorder. Review of R8's quarterly MDS, located under the MDS tab of the EMR and with an ARD of 11/12/24, revealed R8 had a BIMS score of three out of 15, which indicated severe cognitive impairment. Further review revealed R8 required partial/moderate assistance with wheel 50 feet with two turns, wheel 150 feet. Review of the facility's Physical Aggression Initiated form, dated 01/12/25, revealed, Staff reported that [R3] was standing next to a resident after the resident [R8] yelled 'ow get away . The resident reported that [R3] had struck her left shoulder. Residents separated immediately following incident one to one supervision for R3 while out of her room initiated. The resident-to-resident incident of aggression between R3 and R8 was submitted to the state agency, and still within the window of investigation. Review of R3's Care Plan in the EMR under the Care Plan tab, initiated 06/17/23, revealed R3 had the potential to be physically aggressive (hitting others) related to dementia and poor impulse control. Interventions were revised on 01/13/25 after the incident between R3 and R8 to offer for the resident to sit in her chair or lay down on her bed if it seems like she is getting tired from walking. During an interview on 01/16/25 at 2:35 PM, Registered Nurse (RN) 1 said that she was familiar with R3. She stated staff were at the nurse station, getting a resident's vitals, with other residents bunched around the nurse station as well. R3 had come down the hall and the Certified Nursing Assistants had heard that's enough or ow that's enough. They turned around and they saw R8 saying that R3 had hit her in the shoulder. RN1 stated she did not see any injury during the shift. She stated she reported the incident to Quality Improvement (QI) and the QI told her that she would handle the reporting. She stated that R3 had hit other people in the past. She stated if someone was in R3's way, she might act out in the moment. (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/16/25 at 4:33 PM, CNA8 stated R3 had hit R8 on 01/12/25. CNA8 said she was charting and observed R3 was pacing, and then she heard R8 say that was not nice. She said R3 was placed on one-to-one supervision that night and had to have someone with her all the time when she was out of her room. CNA8 said that she had not heard about any day shift problems. She stated that staff had provided her soda and pudding, and that they were trying to find her patterns. She said no one at the facility had contacted her to follow-up, but she had received reeducation on resident abuse. During an interview on 01/13/25 at 11:35 AM, the Administrator stated that the facility had been doing a lot more education on abuse lately. He said that they had restated to the staff that it was not their decision to decide if something was abuse or not. During an interview on 01/15/25 at 8:40 AM, CNA5 stated that when R3 was out of her room, if she started to wander, the staff would put the chair alarm on her resident room door. She stated that R3 pats other residents when she is trying to get around them in the hallway. She stated R3 was not verbal. CNA5 stated that the facility would only put the resident on one to one when they see the behaviors. They would not put her on one-to-one supervision until they thought she might have a behavior. She stated the facility had regular inservicing but could not recall when the most recent education on how to care for R3 was. During an interview on 01/15/25 at 8:53 AM, CNA4 stated that the facility kept the chair alarm on R3's room door so they could know if she was exiting her room because she had a tendency to walk without her walker. CNA4 stated R3 also had behaviors and could get aggressive with residents or staff. She stated she believed the chair alarm would be put on her door at night and when she was observed having behaviors. During an interview on 01/15/25 at 9:26 AM, Licensed Practical Nurse (LPN) 2 stated that the facility had an alarm on R3's door, and when she left her room, it would indicate to staff that she had left her room. LPN2 stated R3 did have behaviors, was rarely verbal, and walked up and down the halls because she used to work at this facility. LPN2 confirmed R3 could become aggressive using her walker as she bumped and hit people as she goes around them. She stated that when the alarm on her door went off, she would be on one-to-one supervision. During an interview on 01/15/25 at 10:32 AM, the Director of Nursing (DON) stated that R3 had some behaviors such as pacing in the hall, refusing care, combativeness with staff, and some resident-to-resident altercations. She stated R3 had some worsening dementia. During an interview on 01/16/25 at 12:50 PM, CNA7 stated the facility had been doing abuse training. She stated that anything could be abuse, including resident to resident or staff to resident. During a concurrent interview on 01/16/25 at 4:50 PM with the Administrator, Registered Nurse Supervisor (RNS), and SSD, it was stated that the facility had believed they had increased education and retraining to improve abuse reporting and investigating. They stated that they believed that following the resident-to-resident abuse guidance, that R3, who had dementia, was not willful in her attempt to hit out at other residents in abusive intent, which they concluded indicated they could not substantiate abuse on the 11/12/24 incident between R3 and R2. They stated that they had continued to develop revisions to her care to prevent ongoing behaviors and had seen improvement. (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility staff were aware that when other residents are in R3's way, R3 has behaviors such as R3 will ram her walker into other Residents or hit other Residents on the shoulder. There is no indication that R3's care plan was updated to include this trigger or interventions to prevent this, resulting in R3 having multiple resident to resident altercations with other residents.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26446 Based on interviews, record review, and facility policy review, the facility failed to ensure an allegation of resident-to-resident abuse for one of four residents (R11) reviewed for abuse out of a total sample of 11 was reported to the state survey agency (SSA) within the required time frame. Findings include: Review of the facility's undated policy titled, Abuse, Neglect and Exploitation, The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse . Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all required agencies . within specified timeframes . Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. Review of R3's electronic medical record (EMR) Profile tab revealed R3 was admitted to the facility on [DATE] with diagnoses of Alzheimer's disease, anxiety disorder, dementia in other diseases severe with agitation, and insomnia. Review of R3's quarterly Minimum Data Set (MDS), located under the MDS tab of the EMR and with an Assessment Reference Date (ARD) of 12/17/24, revealed R3 had a Brief Interview for Mental Status (BIMS) score of 00 out of 15, which indicated significant cognitive impairment. Further review revealed R3 wandered one to three days during the assessment period. It was recorded R3 used a walker and wheelchair for mobility and was supervision or touching assistance when walking ten feet, fifty feet with two turns, and walking 150 feet. Review of R11's EMR Profile tab, revealed R11 was admitted to the facility on [DATE], with a last readmittance of 11/15/24, with diagnoses of anemia, depression, atrial fibrillation, and dysphagia. Review of R11's admission MDS, located under the MDS tab of the EMR and with an ARD of 11/19/24, revealed R11 had a BIMS score of 03 out of 15, which indicated significant cognitive impairment. Further review revealed R11 required partial/moderate assistance with mobility to walk ten feet. Review of the facility's Physical Aggression Initiated form, dated 12/06/24, revealed, Resident [R3] was seen walking down the hallway with her FWW (four-wheel walker). Resident came up behind another resident wheelchair [R11]. Resident [R3] was unable to maneuver her walker around the other residents (sic) [R11] wheelchair . strike resident on their arm . Resident was placed on 1:1 with designated staff . Residents agitation improved after those interventions . Immediate intervention: Staff will offer toileting and check for incontinence frequently and as needed as this is a known agitation. The report documented that the physician and family were informed. It was not reported to the state agency or investigated. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A written statement by Life Enrichment (LE) documented, On Friday, December 6, 2024 at 9:50 AM, I was returning two residents . from the craft fair in the community room . coming down the hall and [R3] bumped her walker into [R11] and before I could get to [R3] she struck [R11] with the side of her fist. [R3] struck [R11] in the right shoulder . I checked on [R11] to see that she was ok. She stated she was. I told her I would let staff know what occurred and she said ok . [R11] appeared fine but had an upset look on her face. The report documented that the physician and family were informed. It was not reported to the state agency or investigated. During an interview on 01/13/25 at 11:35 AM, the Administrator stated that the facility had been doing a lot more education on abuse lately. He stated that they had told the staff that it was not their decision to decide if something was abuse or not. During an interview on 01/15/25 at 3:42 PM, the Administrator stated that the allegation of resident-to-resident abuse between R3 and R11 was not reported because there was no report that R11 had pain. During an interview on 01/16/25 at 9:30 AM, the Social Services Director (SSD) stated that the incident on 12/06/24 with R3 and R11 was not abuse due to no willful intent and no concern from R11. An additional interview at 11:00 AM, SSD stated R11 had short-term memory which was not as good as her long-term memory. She confirmed that R11 was not interviewable. She confirmed the resident-to-resident incident on 12/06/24 was witnessed by staff. SSD stated that the facility wanted staff to report potential abuse with any touching, patting, or if they felt something was wrong. She stated, We have been pushing for that with staff. She stated that they did not report the incident on 12/06/24 between R3 and R11 because they did not feel there were any observable changes in R11 after the incident. During an interview on 01/16/25 at 11:40 AM, Certified Nursing Assistant (CNA) 1 stated that she reported potential allegations of abuse if anyone reports to her or if she sees anything. She stated that resident to resident confrontations could include talking, yelling, pushing, or hitting someone. CNA1 stated if she observed R3 hit anyone, she would consider it a reportable incident. During an interview on 01/16/25 at 12:50 PM, CNA 7 stated the facility had been doing abuse training. She stated that anything could be abuse, including resident to resident or staff to resident. CNA7 stated staff were to report even potential abuse of residents, including those with dementia. During an interview on 01/16/25 at 1:40 PM, LE stated that she was coming through the double doors with two different residents and observed R11 down the hallway. She stated she observed R3 going towards R11 with her walker. She stated that R11 was in her wheelchair going to the dayroom, and R3 was going towards R11. She observed R3 strike R11 with the back of her hand like a swipe. She stated she reported it and filled out a statement right away. LE stated she knew it needed to be reported. She stated she did not believe R11 was injured. LE stated she figured the management was supposed to report it, and since she filled out the information, she believed they had reported it. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/16/25 at 2:35 PM, Registered Nurse (RN) 1 stated that the process for reporting was to notify the Director of Nursing or the Administrator to let them know. She stated they knew to report anything that is abuse, misappropriation of property, or neglect. RN1 stated it was not her job to determine whether it was or was not abuse. She stated they report it so it can be investigated. She stated that if someone was in R3's way, it may not have rhyme or reason, but in the spur of the moment, R3 may hit out. The potential resident-to-resident abuse between R3 and R11 was not reported to the state agancy or reported within the required time frames.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26446 Based on staff interviews, record review, and facility policy review, the facility failed to conduct a thorough investigation for an incident of potential resident-to-resident abuse for one of four residents (R11) reviewed for abuse out of eleven sampled residents. Findings include: Review of the facility's undated policy titled, Abuse, Neglect and Exploitation, revealed, . An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur .Identifying staff responsible for the investigation .Investigation different types of alleged violations .Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations .Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extend, and cause . Providing complete and thorough documentation of the investigation .The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse Review of R3's electronic medical record (EMR) Profile tab revealed R3 was admitted to the facility on [DATE] with diagnoses of Alzheimer's disease, anxiety disorder, dementia in other diseases severe with agitation, and insomnia. Review of R3's quarterly Minimum Data Set (MDS), located under the MDS tab of the EMR and with an Assessment Reference Date (ARD) of 12/17/24, revealed R3 had a Brief Interview for Mental Status (BIMS) score of 00 out of 15, which indicated significant cognitive impairment. Further review revealed R3 wandered one to three days during the assessment period, used a walker and wheelchair for mobility, and was supervision or touching assistance when walking ten feet, fifty feet with two turns, and walking 150 feet. Review of R11's Profile tab of the EMR revealed R11 was admitted to the facility on [DATE], with a last readmittance of 11/15/24, with diagnoses of anemia, depression, atrial fibrillation, and dysphagia. Review of R11's admission MDS, located under the MDS tab of the EMR and with an ARD of 11/19/24, revealed R11 had a BIMS score of 03 out of 15, which indicated severe cognitive impairment. Further review revealed R11 required partial/moderate assistance with mobility to walk ten feet. (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Physical Aggression Initiated form, dated 12/06/24, revealed, Resident [R3] was seen walking down the hallway with her FWW (four-wheel walker). Resident came up behind another resident wheelchair [R11]. Resident was unable to maneuver her walker around the other residents (sic) wheelchair . strike resident on their arm . Resident was placed on 1:1 with designated staff . Residents agitation improved after those interventions . Immediate intervention: Staff will offer toileting and check for incontinence frequently and as needed as this is a known agitation. A written statement by Life Enrichment (LE) documented, On Friday, December 6, 2024 at 9:50 AM, I was returning two residents . from the craft fair in the community room .coming down the hall and [R3] bumped her walker into [R11] and before I could get to [R3] she struck [R11] with the side of her fist. [R3] struck [R11] in the right shoulder . I checked on [R11] to see that she was ok. She stated she was. I told her I would let staff know what occurred and she said ok . [R11] appeared fine but had an upset look on her face. It was recorded R3 was placed on 1:1 with designated staff to ensure the safety of other residents. Review of the facility's Physical Aggression Received form, dated 12/06/24, revealed, Resident [R11] was seen self-propelling in her wheelchair down the hallway when another resident came .resident was unable to get her walker around the residents (sic) wheelchair. The other resident .struck this resident with her arm on her right arm .Immediate intervention: other resident was placed on 1:1 with designated staff to ensure safety of other residents. The report documented that the physician and family were informed. Record review revealed there was an incomplete investigation of the resident-to-resident abuse incident between R3 and R11. A written witness statement from Life Enrichment (LE) was completed and placed in the report, without follow-up. There were no additional staff interviews regarding the behaviors of R3, nor if they had witnessed a similar concern. There were no witness statements from other residents or visitors as it occurred in a common hallway. Residents from the facility were not interviewed to determine if they felt safe residing on the same unit with R3, or if they had experienced similar incidents. During an interview on 01/13/25 at 11:35 AM, the Administrator stated that the facility had been doing a lot more education on abuse lately. He said that they had told the staff that it was not their decision to decide if something was abuse or not. During an interview on 01/15/25 at 10:32 AM, the Director of Nursing stated that R3 had some behaviors such as pacing in the hall, refusing care, combativeness with staff, and some resident-to-resident altercations. She stated R3 had some worsening dementia. During an interview on 01/16/25 at 2:35 PM, Registered Nurse (RN) 1 said that the process for reporting was to notify the Director of Nursing or the Administrator to let them know. She said they knew to report anything that is abuse, misappropriation of property, or neglect. RN1 said it was not her job to determine whether it was or was not abuse. She stated they report it so it can be investigated. She confirmed R3 had hit other people. She stated that if someone was in R3's way, it may not have rhyme or reason, but in the spur of the moment, may hit out. The potential resident-to-resident abuse was not thoroughly investigated.

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	525643	A. Building B. Wing	01/16/2025

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26446 Based on interview, record review, and facility policy review, the facility failed to contact the pharmacy to ensure medications were available for administration for two of three residents (Resident (R) 6 and R9) reviewed for medication administration out of a sample of eleven residents. Findings include: Review of the facility's undated policy titled, Pharmacy Policy and Procedure Omnicell Manual, revealed Nursing Home staff and HealthDirect Pharmacy will use the Omnicell System as an inventory, charging, and information system for the control and distribution of medications for Continuous Dosing, Emergency, and First-Dose use . All licensed staff nurses will have access privileges to controlled medications pursuant to a valid prescription order . All licensed staff nurses will have access privileges to non-controlled medications . Charge Nurses, Director of Nursing, and some Pharmacy personnel may have some of the following privileges . Refilling of non-controlled and controlled medications . Head nurses are able to create a transaction slip that assigns a visiting nurse a Temporary I.D. and Password. This temporary I.D. and password will give the visiting nurse access to the non-controlled medications in the Omnicell System for a timeframe of 1 to 5 days . The nursing home should have at least one resource nurse on each shift. The resource nurse will assist other nurses and will act as the liaison with the Omnicell customer support team . Example 1 Review of R6's Admission Record, found in the Profile tab of the electronic medical record (EMR), revealed he was admitted to the facility on [DATE]. R6 was admitted with diagnoses including chronic obstructive pulmonary disease, abdominal aortic aneurysm without rupture, anxiety, and cerebral infarction. Review of R6's Care Plan, located in the EMR under the Care Plan tab and initiated 04/24/23, revealed R6 had emphysema/chronic obstructive pulmonary disease related to smoking. Interventions included giving aerosol or bronchodilators as ordered and nursing staff will consider awakening the resident in the morning to administer inhalers as ordered, in order to attempt being proactive with his feelings of shortness of breath. Review of R6's quarterly Minimum Data Set (MDS), located in the MDS tab in the EMR and with an Assessment Reference Date (ARD) of 11/05/24, revealed R6 had a Brief Interview for Mental Status (BIMS) assessment with a score of six out of 15, which indicated significant cognitive impairment. It was documented R6 received hospice services. Review of R6's EMR under the Orders tab revealed an order, dated 12/31/23, for Combivent Respimat Inhalation Aerosol Solution 20-100 MCG/ACT (microgram) one puff inhale orally four times a day for SOB [shortness of breath]/Wheeze related to Chronic Obstructive Pulmonary Disease. The Combivent was to be administered at 7:00 AM, 12:00 PM, 4:00 PM, and 8:00 PM. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R6's Medication Administration Record (MAR), located under the Orders tab of the EMR and dated January 2025, revealed no documentation to show the Combivent Respimat Inhalation Aerosol Solution 20-100 MCG/ACT was administered on 01/05/25 at 4:00 PM and 8:00 PM, on 01/06/25 at 7:00 AM, 12:00 PM, and 4:00 PM, and on 01/07/25 at 4:00 PM. Review of R6's Progress Notes tab of the EMR revealed the following documentation related to the Combivent Respimat Inhalation Solution: 01/05/25 at 4:12 PM - no inhaler found. 01/01/25 at 8:26 PM - Med (medication) not available. 01/06/25 at 8:47 AM - resident is out of his Combivent inhaler .was reordered on 12/30/24 and .reordered it today .so he missed yesterday doses and this morning dose. 01/06/25 at 11:38 AM - no supply here pharmacy called and they will be sending it today. 01/06/25 at 4:39 PM - not available. 01/07/25 at 6:30 PM - no med (medicine) available. Review of R6's clinical record revealed an identified concern in an email correspondence on 01/13/25 by R6's power of attorney (POA), with documentation that R6's Combivent inhaler Rx (prescription) was not available. He has missed 5 dosages, 1/5-1/6 and didn't get the RX [prescription] till 1/7. Example 2 Review of R9's Admission Record, found in the Profile tab of the electronic medical record (EMR), revealed she was admitted to the facility on [DATE]. R9 was admitted with diagnoses including essential hypertension, depression, osteoporosis/polymyalgia rheumatica, gastroesophageal reflux disease, heart failure, and anxiety. Review of R9's Care Plan in the EMR under the Care Plan tab and initiated 12/26/24, revealed R9 had osteoporosis/polymyalgia rheumatica. Interventions included administering analgesia as per orders, anticipating her need for pain relief and responding immediately to any complaint of pain. It was also recorded that R9 had anxiety and took sertraline. Interventions included administering medications as ordered. Review of R9's Care Plan in the EMR under the Care Plan tab, initiated 12/26/24, revealed R9 had anxiety and took Sertraline. Interventions included administering medications as ordered. Review of R9's admission (MDS, located under the MDS tab in the EMR and with an Assessment Reference Date (ARD) of 12/31/24, revealed R9 had a BIMS score of 15 out of 15, which indicated no cognitive impairment. It was documented that R9 received an antidepressant, anticoagulant, and diuretics. a Review of R9's EMR under the Orders tab revealed an order dated 12/26/24 for Famotidine Oral tablet 20 MG (milligram), give one table by mouth at bedtime related to gastroesophageal reflux disease without esophagitis. The famotidine was to be administered daily at 8:00 PM. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R9's MAR, dated 01/2025 and located under the Orders tab of the EMR, revealed R9 was not administered the famotidine 01/03/25, 01/05/25, and 01/06/25. Review of R9's Progress Notes tab of the EMR revealed the following documentation related to the famotidine: 12/30/24 at 9:02 PM - n/a (not available). 01/03/25 at 8:14 PM - on order. 01/05/25 at 8:26 PM - medication not available. On order. 01/06/25 at 9:10 PM - medication not available; waiting for delivery from pharmacy. Review of R9's EMR under the Orders tab revealed an order dated 12/27/24 for Prednisone Oral Tablet 2.5 MG, give one tablet by mouth one time a day related to polymyalgia rheumatica. The Prednisone was to be administered daily at 8:00 AM. Review of R9's MAR, dated 01/2025 and located under the Orders tab of the EMR, revealed no documentation that R9's prednisone was administered on 01/01/25 and 01/02/25. Review of R9's Progress Notes tab of the EMR revealed the following documentation related to the prednisone: 01/01/25 at 9:08 AM - on order. 01/02/25 at 8:59 AM - on order. Review of R9's EMR under the Orders tab revealed an order dated 12/27/24 for Sertraline HCl Oral Tablet 50 MG, give one tablet by mouth one time a day related to generalized anxiety disorder. The sertraline was to be administered daily at 8:00 AM. Review of R9's MAR, dated 01/2025 and located under the Orders tab of the EMR, revealed no documentation that R9's sertraline was administered on 01/01/25 and 01/02/25. Review of R9's Progress Notes tab of the EMR revealed the following documentation related to the sertraline: 01/01/25 at 9:08 AM - on order. 01/02/25 at 9:00 AM - on order. Facility provided documentation of the Omnicell Medication contents revealed that famotidine 20 mg, prednisone 1 mg, 10 mg, and 20 mg, and sertraline 50 mg were all available in the onsite system. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/15/25 at 9:26 AM, Licensed Practical Nurse (LPN) 2 stated that she was an agency nurse but worked at the facility as needed. LPN2 stated she could reorder medications in the EMR, and she could fax if she needed a new prescription. She stated she did not know if the facility had given her access to the Omnicell system, but if she knew she could, she would go to management to get permission to use it. She stated as an agency nurse, she was not given permission to access the medications in the Omnicell. During an interview on 01/15/25 at 9:33 AM, Registered Nurse (RN) 3 stated she was an agency nurse. She stated that if a resident needed medication that was not available, she would call the pharmacy or contact them through the EMR. She stated she was not aware of an Omnicell system at the facility to access medications onsite. During an interview on 01/15/25 at 10:17 AM, LPN1 stated she was not aware that the facility had an Omnicell system to access medications. She stated that she would contact the pharmacy if a medication was not found. During a concurrent interview on 01/15/25 at 10:24 AM with the Pharmacist and the Director of Nursing, the Director of Nursing stated that the facility had an Omnicell system, or nurses could call pharmacy for an order, or use the EMR to order medications. She confirmed the facility nurses had access to the Omnicell and that the regular nurses had access to. She stated that they were looking to get more frequent agency staff access to it as well. The Pharmacist stated the Omnicell was stocked very robustly with medications. The DON stated that if the facility identified that a medication had been coded as not given to a resident, they should contact the pharmacy, contact a local pharmacy, or look into getting a different medication. She stated that they would alert the provider and pharmacy if the resident had gone multiple days without medication. She stated that for new admit residents, the medications would be faxed to the pharmacy and should arrive by night shift. She stated if a medication was pertinent or needed to be given immediately, after reviewing the medication reconciliation, they look to see if it was in their contingency supply to provide them. The DON confirmed she would not expect residents to go multiple days without medications. She also confirmed that R6's Combivent was reordered but was missed by pharmacy and sent at a later date. She stated the resident should not have missed his Combivent. During an interview on 01/15/25 at 11:33 AM, Quality Improvement (QI) and the Administrator stated that they had identified that medication orders were not placed correctly into the system for R6 to get his Combivent and that he did miss a number of doses of it. The Administrator stated that they had developed a performance improvement plan (PIP) to work on getting medications in from pharmacy, as staff have realized they are at the end of the pharmacy's run. During an interview on 01/16/25 at 10:28 AM, R9 stated that when she was admitted to the facility there had been a real problem in getting her medication in from pharmacy. She said she was not aware of why there was a delay in providing the medicine. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/16/25 at 4:30 PM, RN2 stated that she was an agency nurse. She stated that she had to reorder medications through the EMR but was told by another nurse that the system did not work very well. She stated that the other nurse told her that she faxed the reorders to the pharmacy, but it did not seem to work as well as it should. RN2 stated the agency nurses were told that they did not get access to the Omnicell and that none of the staff nurses had volunteered to help them get access to the system. RN2 stated that if a resident's medication was not available, some nurses did not have time to hunt down a way to get the orders filled. She stated that was why she believed there are a lot of progress notes indicating the medication was on order and not available. RN2 stated access to the Omnicell would help considerably. During a concurrent interview on 01/16/25 at 4:50 PM with the Administrator, Registered Nurse Supervisor (RNS), and Social Services Director (SSD), RNS confirmed that the facility believed it was possible the nurses were not hitting receive on the EMR when requesting medications from the pharmacy so that medications would be processed and submitted. RNS also stated that some of the agency nurses had come to her the other day to ask for help getting into the Omnicell. It was confirmed in the interview that they did not want residents to go without medications. The Administrator stated he wanted to see the attempts to get the medications documented and they have put notes on the medication carts to let nurses know if they need medications from the Omnicell, they can get help accessing it.