

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525643	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/29/2025
NAME OF PROVIDER OR SUPPLIER Pleasant View Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0603</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from separation (from other residents, his/her room, or confinement to his/her room).</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and policy review, the facility failed to ensure 2 of 9 residents (R) sampled for review of Abuse (R1 and R2) were free from involuntary seclusion.</p> <p>Findings include:</p> <p>Review of the facility's undated Abuse, Neglect, and Exploitation Policy and Procedure, provided by the Administrator, noted Involuntary Seclusion refers to the separation of a resident from other residents or from his/her room or confinement to his/her room against the resident's will or the will of the resident's legal representative. Emergency or short term monitored separation from other residents will not be considered involuntary seclusion and may be permitted if used for a limited time as a therapeutic intervention to reduce agitation until professional staff can develop a plan of care to meet the resident's needs as long as the least restrictive approach is used for the minimum amount of time.</p> <p>Example 1</p> <p>Review of the Face Sheet located in the electronic medical record (EMR) under the Profile tab revealed R1 was admitted [DATE] with diagnoses that included unspecified dementia with agitation and sleep disorder.</p> <p>Review of the quarterly Minimum Data Set (MDS) located under the MDS tab in the EMR with an assessment reference date (ARD) of 05/06/25 revealed a Brief Interview for Mental Status (BIMS) score of 0 out of 15 which indicated R1 was severely cognitively impaired. The MDS indicated R1 could ambulate independently and wore a wander guard alarm daily.</p> <p>Review of the comprehensive care plan, provided by the Social Services Supervisor (SSS) dated 04/16/25 revealed that R1 was an elopement risk and wandered related to dementia, disorientation, wandering aimlessly, and impaired safety awareness. Interventions included to distract me from wandering by offering pleasant diversions, structured activities, food, conversation, walking and identify my pattern and purpose of wandering, provide structured activities, toileting, walking inside and outside, reorientation strategies including signs, pictures, and memory boxes. R1 wears a wander guard.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0603</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's investigation, provided by the Administrator, dated 03/13/25 revealed on 03/06/25 at 6:30 AM, the Maintenance Assistant (MA) observed a mechanical lift impeding an egress as the lift blocked one side of the fire door and the other side of the fire door was closed between rooms [ROOM NUMBERS]. The investigation summarized that an agency Certified Nursing Assistant (ACNA) closed one fire door and blocked the other fire door with an unlocked mechanical lift, placed for convenience to deter (R1) from going into other resident's room. The incident was identified as an intentional act of involuntary seclusion. The ACNA was removed from the facility and terminated from employment in the facility.</p> <p>During an interview on 05/28/25 at 2:25 PM, the MA confirmed that between 6:00 and 6:30 AM on 03/06/25, he saw one side of the fire door blocked, and the other fire door closed on the View unit. The fire doors were located between rooms [ROOM NUMBERS]. The MA said he removed the mechanical lift, opened the fire door, and immediately notified his supervisor. The MA stated, I reported it right away because that's what you do when something isn't right.</p> <p>On 05/29/25 at 9:40 AM, the Administrator provided all staff training records from 10/30/24, 10/31/24, and 11/07/24 for Abuse prevention training which included involuntary seclusion The Administrator stated, The staff were trained, they should have known better.</p> <p>Interview on 05/29/25 at 1:00 PM, the SSS confirmed that this was involuntary seclusion.</p> <p>Example 2</p> <p>Review of the Face Sheet located in the EMR under the Profile tab identified R2 was admitted [DATE] with diagnoses that included Alzheimer's disease, and dementia with agitation. R2 died on [DATE].</p> <p>Review of the annual MDS located under the MDS tab in the EMR with an ARD of 03/25/25 revealed a BIMS score of 0 out of 15 which indicated R2 was severely cognitively impaired. The MDS indicated R2 could ambulate independently and wore a wander guard alarm daily.</p> <p>Review of the comprehensive care plan dated 02/05/25 revealed that R2 has the potential to be physically aggressive related to dementia and poor impulse control. R2 communicates with others by striking out due to not aware how to communicate. Interventions included give me as many choices as possible about care and activities; require increased supervision by one staff member through investigation of resident-to-resident altercation that occurred on 08/12/24; if agitated please distract me with an activity such as offer me a washcloth to wipe down railings in hallways; and that my behaviors can be decreased by walking outside, doing meaningful activities such as cleaning, wiping hand railings, folding clothes, and helping staff. I feel like I work here.</p> <p>Review of the behavior tracking logs located under the Tasks tab in the EMR dated 01/03/25 revealed R2 was identified to have no behaviors, grabbing others, hitting others, pushing others, physically aggressive toward others, accusing of others, expressing frustration at others, screaming at others, and threatening others.</p> <p>Review of the facility's investigation, provided by the Administrator, dated 01/06/25, revealed On January 4th, 2025, staff contacted the Interim Administrator and informed them that Resident Assistant (RA1) was seen by two staff members putting R2 into her room and shutting the door .</p> <p>(continued on next page)</p>		

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<p>F 0603</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of RA1's statement, located within the facility investigation, read, During dinner, [R2] was kind of walking around and not staying in her seat. When we directed her to eat, she didn't. Throughout the night she was trying to go into other rooms, and she didn't like being redirected. Toward the end of my shift, when she got very violent with me, she picked up (staff) sweatshirt. She flipped her switch on me and started hitting me while we were in her room and picked up her water mug and tried to hit me with it. I closed the door for my safety so I wouldn't get hit and that's when [CNA2] came in and took over. [R2] tried to swing the mug .sat on her bed, I shut the door, and that's when she started yelling help.</p> <p>Interview on 05/27/25 at 3:20 PM, CNA2 stated, I came onto the unit after my break and saw [RA1] taking [R2] with her arm on the resident's back, to her room and shutting the door. [R2] was yelling for help so I went to her room and helped her out. I was able to calm her down and then help her to bed.</p> <p>Interview on 05/29/25 at 1:00 PM, the SSS stated, During her investigation of this incident, R2 was identified to have been sitting quietly at the nurses' station prior to the incident. RA1 should not have made R2 go to her room. RA1 was angry with R2 for her earlier behaviors. RA1 was terminated.</p>