STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525724	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grace Lutheran Communities - River Pines	206 N Willson Dr Altoona, WI 54720

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review, the facility did not ensure that appropriate information is communicated to the receiving health care institution or provider for 1 of 1 resident (R22) reviewed for hospitalizations.Facility did not communicate with the hospital emergency department (ED) prior to R22's transfer of the reason R22 needed to be transferred. This is evidenced by:On 05/20/26, Surveyor reviewed R22's medical record. R22's diagnoses include displaced trimalleolar fracture of right lower leg, anemia, congestive heart failure, mild cognitive impairment, COPD, chronic kidney disease stage 3B, restless legs, depression, type 2 diabetes mellitus, and dementia.R22's progress notes documented 05/03/2026 9:25 PM, Health Status Note,Note Text: Pt transferred to ED for evaluation after unresponsive episode. Pt noted to be unresponsive with heart beat and active respirations at 1920 (7:20 PM). Last known well time 18:15 (6:15 PM). POA Updated. Resident was not tracking with eyes, unable to verbalize responses to questions or follow commands.R22's medical record did not document communication with the hospital ED of R22's reason of being transferred to the ED. On 05/21/26 at 11:41 AM, Surveyor interviewed Director of Nursing (DON) B asking if the hospital was notified of R22's reason for transfer. DON B stated DON B was notified of R22 having another unresponsive episode. It was an agency nurse and DON B doesn't have access to that nurse. The nurse no longer works at the facility. There is a packet for discharge, and the nurses will fax the communication sheet to the ED of information of resident and reason for transfer. This is because of the stress of the hospitals from the 2 hospitals closing and staff at the ED are busy and not always able to take verbal report. DON B stated DON B looked in the hospital record system and did not find facility's communication of contact to the hospital of R22's reason of transfer.

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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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure 3 of 5 (R22, R3 and R4) sampled residents received care and treatment in accordance with assessments and professional standards of practice to ensure their highest practicable physical, mental, and psychosocial well-being. The facility staff did not complete a full assessment when changes in condition occurred, did not assess upon re-admission, and did not coordinate care plans with hospice to ensure consistency and continuity of care. On 05/03/26, the facility did not complete and document a full assessment of R22's change of condition and on 05/04/26 did not complete and document a re-admission assessment. The facility did not coordinate R3's care plans with hospice to ensure consistency and continuity of care. The documentation of R4's cares do not support R4 was receiving a shower twice weekly as care planned. R4 was not placed in the correct Hoyer sling size, and a Hoyer sling size was not documented in the hospice care plan. This is evidenced by: Facility's policy titled Acute Condition Changes – Clinical Protocol dated 05/01/26 documented 5. Before contacting a provider about someone with acute change of condition, the nursing staff will make detailed observations and collect pertinent information to report to the provider. Phone calls to attending or on-call providers should be made by an adequately prepared nurse who has collected and organized pertinent information, including the resident's current symptoms and status. C. Nurses are encouraged to use the SBAR Communication Form and Progress note (Interact Version 4.5) as a tool to help gather and organize information before notifying the provider. Facility's policy titled admission Assessment and follow-up: Role of the Nurse dated 10/10/16 documented Steps in the Procedure.7. Complete a Head to Toe Assessment. 8. Conduct supplemental assessments including, but not limited to: a. Activity level; b. Pain assessment, c. Fall risk assessment, d. Neurological assessment, e. Skin assessment, f. Functional assessment Example 1 R22's diagnoses include displaced trimalleolar fracture of right lower leg, anemia, congestive heart failure, mild cognitive impairment, COPD, chronic kidney disease stage 3B, restless legs, depression, type 2 diabetes mellitus, and dementia. Minimum Data Set (MDS) documented on 05/03/26 a discharge return anticipated submission and on 05/04/26 an entry to the facility submission. R22's progress notes documented 05/03/2026 9:25 PM, Health Status Note,Note Text: Pt transferred to ED for evaluation after unresponsive episode. Pt noted to be unresponsive with heart beat and active respirations at 1920 (7:20 PM). Last known well time 18:15 (6:15 PM). POA Updated. Resident was not tracking with eyes, unable to verbalize responses to questions or follow commands. R22's medical record on 05/03/26 at 7:20 PM did not document a full assessment with vital signs, did not document using the SBAR form, and did not document the provider was updated and if any orders were provided. The medical record did not document R22's diagnosis and admission to the hospital. On 05/04/26, R22 returned from the hospital. R22's medical record did not document a full (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessment upon re-admission to the facility and discharge diagnoses. No vitals were entered into the medical record. 05/21/26 at 11:41 AM, Surveyor interviewed Director of Nursing (DON) B asking if assessments of R22 were completed prior to transfer and upon return to facility. DON B stated DON B was notified of R22 having another unresponsive episode. At that time, it was an agency nurse and currently don't have access to that nurse as that nurse no longer works at the facility. DON B stated DON B is unable to find a completed assessment with vitals, provider notification or order, and no SBAR when R22 was transferred to the ED. DON B could not find an assessment of R22 upon re-admission. DON B stated DON B would expect an admission assessment to be completed. Example 2 R3's diagnoses include gangliosidosis, dystonia, respiratory disorder, major depressive disorder, anxiety disorder, respiratory failure, dysphagia, disorder of the autonomic nervous system, contracture of muscle left forearm, immunodeficiency, restless legs syndrome, anemia, psychotic disorder with delusions, aphasia, functional quadriplegia, protein-calorie malnutrition, and phonological neuromuscular. On 03/13/26, MDS documented a Brief Interview of Mental status (BIMS) score of 15/15, meaning intact cognition. R3 is dependent on staff for all activities of daily living. R3's facility's care plan documented:The resident has a terminal prognosis r/t GM1 Date Initiated: 08/26/2025 The resident's comfort will be maintained through the reviewdate. Date Initiated: 08/26/2025 Revision on: 09/09/2025Target Date: 08/27/2026 Work cooperatively with [Name] Hospice team to ensure the resident's spiritual, emotional, intellectual, physical and social needs are met. Date Initiated: 08/26/2025. The care plan did not address R3's choices, preferences and goals when nearing the end of life regarding pain management and symptom control, treatment of acute illness, and choices regarding hospitalization. R3's hospice communication book documented by CNAs of showers given each week and bedding changed. The communication book did not include the hospice care plan for R3. On 05/21/22026 at 11:41 AM, Surveyor interviewed DON B about hospice care plan and coordination of care. DON B stated every Friday DON B goes over any changes with the hospice nurse. This is verbal communication with hospice nurse if there are any changes. We don't go over the care plans to see if they are the same. Hospice gives a weekly calendar for showers and social visits. Example 3 R4 was admitted to the facility on [DATE], with diagnoses including dementia, history of stroke, heart failure, and respiratory failure. R4 was admitted to hospice services on 04/08/26. On 05/20/26, Surveyor reviewed R4's facility and hospice care plans. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R4's facility care plan included: Resident has a terminal diagnosis related to hear failure, 04/28/26. Interventions: Adjust activities of daily living to resident's changing abilities. Work with hospice team to ensure the resident's spiritual, emotional, intellectual, physical and social needs are met. Activities of Daily Living (ADLs), 05/24/23. Interventions: Bathing/showering, check nail length and trim and clean on bath day as necessary, report any changes to the nurse. Resident is totally dependent on mechanical transfer, extra large sling to provide shower weekly and as necessary. R4's hospice Aide Care Plan Report included: Home health aide twice weekly. Bathing task to be completed every visit, two assist with hoyer lift transfer, 04/08/26-07/06/26. Surveyor noted R4's hospice care plan did not indicate the size sling R4 was to use. On 05/20/26, Surveyor reviewed the facility and hospice documentation related to R4's showering tasks. Surveyor noted showering/bathing for the facility was located in the tasks tab of R4's electronic record and options included, Who bathed resident? facility staff, hospice, refused, not applicable (N/A). R4's documentation included the following: 04/11/26-N/A 04/18/26-N/A 04/25/26-N/A 05/02/26-N/A 05/09/26-N/A 05/14/26-HOSPICE 05/16/26-N/A Surveyor noted bathing/showering completed by hospice is documented in the paper hospice binder located at the nurses' station, and included: 04/16/26, hospice aide, showered, dressed, brushed teeth, socialized, brought down for breakfast, cleaned up room. 05/14/26, hospice aide, shower completed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	05/21/26, hospice aide, showered, clean bedding, brought down to breakfast. On 05/20/2026 at 11:51 AM, Surveyor interviewed facility certified nursing assistants (CNAs) D and E. CNAs D and E stated R4 is on hospice and receives a shower on Thursdays when the hospice aide visits. CNA D reported facility CNAs assist hospice aide with R4's shower on Thursdays as R4 requires two staff to transfer with a mechanical lift. CNA D stated hospice aides chart showers in hospice binder and facility CNAs document showers in the task and will indicate who gave the shower, example facility staff or hospice. If the resident refuses, CNAs would document resident refused and tell the nurse. CNA D thinks the nurse is required to document the refusal. On 05/21/2026 at 7:08 AM, Surveyor observed two CNAs from hospice assisting R4 with cares after shower. Surveyor interviewed hospice aides F and G. Hospice aides F and G reported communication with facility staff is verbal, and R4 gets a shower weekly on Thursdays. Hospice aides F and G were not sure if facility staff completed a shower a different day of the week. Hospice aides F and G stated hospice has two aides coming due to R4 being a hoyer lift transfer and hospice aides having to wait for facility staff to assist them, up to 20 minutes. Hospice aides F and were not sure why R4's hospice care plan indicated R4 received a shower every visit, as they only shower/bathe R4 once weekly on Thursdays. On 05/21/2026 at 8:16 AM, Surveyor and CNA I observed R4 was in a size large sling and R4's care plan indicated R4 was measured for an extra large sling. CNA I showed Surveyor the shower room where slings are kept and noted there were extra slings in the room. CNA I was not sure why R4 was in a large sling. On 05/21/2026 at 8:48 AM, Surveyor interviewed hospice Registered Nurse (RN) H. Hospice RN H stated hospice has very good communication with the facility. Hospice RN reported facility and hospice CNAs communicate to her daily, and she has daily communication with the facility's Director of Nursing (DON). Hospice RN stated, I would assume facility staff is giving her a shower, our CNAs come twice a week, one for social once for shower. Yes, communication is verbal. I meet with DON on Fridays to wrap up the week. The aides have not reported concerns to me. Hospice RN H stated she did not realize R4's hospice care plan indicated R4 would receive a shower twice weekly. The facility and hospice documentation of R4's cares do not support R4 was receiving a shower twice weekly as care planned. Hospice aides did not place R4 in the correct hoyer sling size, and a hoyer sling size was not documented in the hospice care plan. The facility did not have a system to communicate what services would be provided to R4 and which provider would complete those services. The hospice and facility staff were unable to report a communication system other than a verbal one.