STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525409	A. BUILDING _____ B. WING _____	05/27/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PINE VIEW CARE CENTER	400 COUNTY RD R BLACK RIVER FALLS, WI 54615

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 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not ensure residents receive adequate supervision for 1 of 3 total sampled Residents (R1). R1 had left the building on 4/29/20. R1 was not reassessed for an elopement risk and R1's care plan was not updated timely. This is evidenced by: Facility Policy entitled 'Elopement and Wandering Management,' dated 3/18, states, in part: Purpose: It is the policy of this facility to make every reasonable effort to provide for the safety and security of residents at risk for elopement, while maintaining the least restrictive environment and preserving their independence in mobility. Resident wandering behaviors must be assessed and monitored in order to protect the safety and welfair of residents. Protocol: .2. For each resident identified as having wandering behavior and/or as having elopement potential, an appropriate safety care plan . will be developed and implemented with specific approaches, preventative measures and measurable goals . 5. All residents identified with elopement/wandering potential will wear an alert bracelet as appropriate until the residents behavior warrants discontinuation . 9. All instances of elopement attempts will be documented in the Nurse charting tab . For the purposes of this policy, a resident elopement is defined as the situation where a cognitively impaired resident with impaired safety judgment leaves the facility without staff knowledge . R1 was admitted on [DATE], with a [DIAGNOSES REDACTED]. On 1/9/20 at 6:34 PM, R1's Elopement/Wandering Assessment, indicates R1 has dementia, and is able to propel himself in a wheelchair. R1 has no history of wandering or elopement. R1's Quarterly MDS (Minimum Data Set) dated 5/13/20, indicates R1 has a BIMS (Brief Interview of Mental Status) of a 4 out of 15, which indicates R1 is severely cognitively impaired. R1 is independent with transfers and bed mobility. R1 is indicated as being able to ambulate independently. Section E indicates that R1 did not exhibit any type of behaviors such as delusions, hallucinations, physical, verbal or wandering during this 7 day look back period. R1's CNA (Certified Nursing Assistant) Assignment Sheet, printed 5/27/20 at 2:45 PM, indicates R1 is able to turn/reposition himself independently. Special Care Remarks, states in part Alert/oriented has periods of forgetfulness/confusion .increase rounding on resident when in his room. Resident likes listening to classic country music. He has done word search, jigsaw puzzle, cards ([MEDICATION NAME], 500, schmere). He likes reading the Banner Journal and occasionally looking at magazines. He likes to watch western shows, Wheel of Fortune, Price Is rRight and the news. There is no indication on the CNA assignment sheet that R1 is at risk for elopement or wandering. R1's Care Plan, dated 5/27/20 at 1:30 PM, States, in part: Problem: potential for exit seeking. Related to: confusion/dementia. Manifested by: exit seeking statements. Goal: Resident will remain safe. Goal time: 07/17/2020 three months. Nurse aide --- Redirect if making statements, engage in activity. Nurses --- report if attempt to leave facility is made. R1's Care Plan for alteration in thought processes, states in part: 04/15/2020 10:58 PM Nurse Aide --- Redirect and reorient resident when needed. Explain procedures and cares as they are provided. Monitor resident for elopement from building and redirect as needed. These interventions indicated on R1's Care Plans for CNA's to follow are not indicated on the CNA assignment sheet which are signed off on each day by CNA's. On 4/15/20 at 10:54 PM, R1's Progress Note indicates Observed outside at 9:20 PM, resident was brought back into building. Assessment supporting intervention: Staff aware of res elopement, staff will be monitoring through shift. On 4/16/20 at 2:42 AM, R1's Progress Note indicates night shift resident was observed in his room sleeping, no attempts at elopement noted. On 4/16/19 at 9:07 AM, R1's Progress Note states, in part: Follow-up of incident: observed outside. .(R1) was not attempting to leave the facility. He does like to get fresh air. He did not know the doors were locking behind him. He is aware he does need to let staff know when he goes outside and to push the doorbell to come back inside the building. He is able to repeat this information to writer. He did not have any ill effect from being outside. On 4/18/20 at 1:12 PM, R1's Progress Note states in part: Resident crawling on floor this AM with flash light and wandering into other residents rooms in his underwear friengtening (sic) other residents. Resident very confused this AM. On 4/19/20 at 10:23 PM, R1's Progress Note states, in part: Nurse from 100/200 wing reports res (resident) exit seeking and not responding to redirection before supper. On 4/19/20 at 10:25 PM, R1's Progress Note, states, in part: Res staying in unit for several hours, refused to eat supper. Res quiet from 1900 (7 PM) in unit until bedtime in own room. Res responded well to 1:1 (one to one) after several hours. On 4/29/20 at 11:39 PM, R1's Progress Note, states, in part: Behavior: Res went out patio door and tried to climb fence to elope. Res returned to building and went out 200 door hallway. 1:1 with res for 40 minutes by this writer. Res. sat in hallway refusing to return to unit. Res stating They can't hold me here. Res eventually exchanged pleasant conversation with this writer and returned to unit. Cooperative to take HS medication. There is no new elopement/wandering assessment completed for R1 after R1 went out of the facility on 4/29/20. On 5/27/20 at 12:50 PM, Surveyor interviewed CNA E regarding wandering residents. CNA E indicated that Residents who are trying to escape are considered at risk. CNA E indicated that most of the wanderers are in the back on the Memory Care Unit. CNA E indicated the Care Plan will say if a resident is a wander risk. CNA E indicated the alarm on the doors will go off if trying to get out and it lights up on the board at the nurse's station to let you know which door. CNA E indicated the CNA Assignment Sheets are signed off by CNA's daily. On 5/27/20 at 1:12 PM, Surveyor interviewed DON B (Director of Nursing) regarding R1. DON B indicated that R1 was moved to the Memory Care Unit around 4/23/20. DON B indicated that R1 was moved off of the Memory Care Unit on 5/25/20 due to roommate becoming ill. DON B indicated non-pharmacological interventions were R1 and his roommate became buddies and R1 settled into his new room. DON B indicated that R1 was treated for [REDACTED]. DON B indicated staff are not always charting non-pharmacological interventions, but staff do provide 1:1's and ice cream to R1. DON B indicated wandering residents are located in a Happy Feet book on the living units. DON B indicated their trying to do elopement assessments more frequently. DON B indicated R1 does not have an elopement assessment completed on or after 4/29/20 when he went out of the building. DON B indicated R1 should have had an assessment completed. On 5/27/20 at 3:55 PM, Surveyor interviewed LPN D (Licensed Practical Nurse) regarding R1 going out on 4/29/20. LPN D indicated that she doesn't remember if the alarm went off or if someone told her he was outside. LPN D doesn't remember the incident specifically and is unable to say when it occurred. LPN D indicated the 200 hall door is the door between the 200 hall and the Memory Care Unit. On 5/27/20 at 5:28 PM, Surveyor interviewed NHA A (Nursing Home Administrator) and DON B regarding R1. DON B indicated the interventions are on the CNA care plan and are to be used in general, when residents are bored. DON B indicated CNA's do not document behaviors and nurses are not documenting behavioral interventions as they should. NHA A indicated R1 was in room (room number) at first, then was moved down to the Memory Care Unit, which caused behaviors and R1 was being treated for [REDACTED].
F 0758 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is**

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

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.

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F 0758

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Few

(continued... from page 1)

necessary and PRN use is limited.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on interview and record review the facility did not ensure each Resident receives non-pharmacological interventions for targeted behaviors, residents do not receive PRN (as needed) antipsychotic medications unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record, and PRN orders for antipsychotic medications are limited to 14 days, and renewed every 14 days by a provider, with documentation of evaluation and rationale in the residents medical record for 1 of 1 Residents out of a total sample of 3 Residents (R1). R1 has a [DIAGNOSES REDACTED]. R1's PRN was not re-evaluated every 14 days to ensure the PRN [MEDICATION NAME] is appropriate. R1 has no documentation of non-pharmacological interventions being used before using PRN [MEDICATION NAME]. This is evidenced by: Facility Policy entitled 'Psychoactive Medication Protocol,' dated 9/2017, states, in part: Purpose: To ensure appropriate procedures and subsequent documentation is completed prior to the initiation or change of a psychoactive medication and to ensure ongoing targeted behavior tracking for comprehensive assessment and evaluation purposes. Protocol: 1. psychoactive medications include antipsychotics, antianxiety agents, sedatives, hypnotics and antidepressants. 2. The Interdisciplinary Team will identify target behaviors and develop a care plan to include treatment goals and evaluation of precipitating events, if any, in the resident's environment. The care plan should include alternatives to the staff's approach to care giving, environemental interventions and other interventions as indicated. .5. Physician order [REDACTED].e reduction in the frequency or severity of a targeted behavior) for any psychoactive medications. 6. Specific requirements for the use of PRN [MEDICAL CONDITION] medications are referenced . There must be an evaluation of the resident before writing a new PRN order for antipsychotic medications: [REDACTED]. b. The attending Physician or prescribing practitioner should, at a minimum, determine and document the following in the resident's medical record: i. is the antipsychotic medication still needed on a PRN basis? Ii. What is the benefit of the medication to the resident? Iii. Have the resident's expressions or indications of distress improved as a result of the PRN medication . Table 1: . PRN orders for antipsychotic medications only. Time limitation: 14 days. Exception: None. Required actions: if the attending Physician or prescribing practitioner wishes to write a new order for he PRN antipsychotic, the attending physician or prescribing practitioner must first evaluate the resident to determine if the new order for the PRN antipsychotic is appropriate. R1 was admitted on [DATE], with a [DIAGNOSES REDACTED]. R1's Quarterly MDS (Minimum Data Set) dated 5/13/20, indicates R1 has a BIMS (Brief Interview of Mental Status) of a 4 out of 15, which indicates R1 is severely cognitively impaired. R1 is independent with transfers and bed mobility. R1 is indicated as being able to ambulate independently and use the bathroom independently. Section E indicates that R1 did not exhibit any type of behaviors such as delusions, hallucinations, physical, verbal or wandering during this 7 day look back period. R1's Physician order [REDACTED]. R1's Physician order [REDACTED]. Per the Centers for Medicare & Medicaid Services (CMS) (https://www.cms.gov/Medicare/Coding/ICD10/2020-ICD-10-CM) ICD 10 (10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD)) coding of F0391 means Unspecified dementia with behavioral disturbance. There is no evidence in R1's chart that R1 had a face to face or telehealth evaluation from a provider to indicate and document the rationale or reasoning that R1 needs to use PRN [MEDICATION NAME] or [MEDICATION NAME] or the rationale for being used longer than 14 days. (Telehealth is the distribution of health-related services and information electronically over a computer, tablet or cellphone.) R1's CNA Assignment Sheet, printed 5/27/20 at 2:45 PM, indicates R1 is able to turn/reposition himself independently. Special Care Remarks, states in part Alert/oriented has periods of forgetfulness/confusion .increase rounding on resident when in his room. Resident likes listening to classic country music. He has done word search, jigsaw puzzle, cards ([MEDICATION NAME], 500, schmere). He likes reading the banner journal and occasionally looking at magazines. He likes to watch Western shows, Wheel of Fortune, Price Is Right, and the News. R1's CNA sheet does not indicate to monitor R1 for any type of targeted behaviors or what to do if/when R1 does have any type of behaviors. R1's CNA sheet also does not indicate R1 wanders or exit seeks. R1's April 2020 TAR (Treatment Administration Record) states, in part: Entry date: 04/29/2020 (ant-psychotic) Targeted behavior for: [MEDICATION NAME] Wandering; wandering NOC (nights) AM (days) PM (evenings). R1 is indicated as having tried to exit seek on the following days: 4/29 - PM shift 10 times 4/30 - PM shift 5 times R1's April 2020 PRN MAR indicated [REDACTED]. R1's May 2020 TAR indicates Targeted behavior for: [MEDICATION NAME] is wandering. R1 is indicated as wandering multiple times on the follow dates during AM shift: 5/2, 5/3, 5/9-5/11, 5/14, and 5/16 - 5/20. R1 is indicated as wandering multiple times on the follow dates on PM shift: 5/1, 5/2, and 5/4- 5/22/20. R1 is indicated as not having any wandering events on NOC shift. R1's May 2020 PRN MAR indicated [REDACTED]. On 4/5/20 at 10:28 PM, R1's Progress Note indicates Behavior, CNA reports increased confusion this shift. R1 was taking off clothes, and talking about work. R1 was rummaging in room and through drawers of roommate. PRN Tylenol given at HS for comfort. On 4/7/20 at 1:01 PM, R1's Progress Note, states, in part: Behavior: Resident seen eating off of roommates tray at lunch time. On 4/9/20 at 5:47 AM, R1's Progress Note, states, in part: Approximately 0535 (5:35 AM) resident was noted sleeping in room [ROOM NUMBER]. When approached by staff resident stated calmly Is it 0630 (6:30 AM) already. Staff attempted to redirect resident with no success. Resident remains in room (room number) at this time. Staff will continue to encourage resident to utilize proper room. On 4/15/20 at 10:54 PM, R1's Progress Note indicates Observed outside at 9:20 PM, resident was brought back into building. Assessment supporting intervention: Staff aware of res elopement, staff will be monitoring through shift. On 4/16/20 at 2:42 AM, R1's Progress Note indicates night shift resident was observed in his room sleeping, no attempts at elopement noted. On 4/16/19 at 9:07 AM, R1's Progress Note states, in part: Follow-up of incident: observed outside. .(R1) was not attempting to leave the facility. He does like to get fresh air. He did not know the doors were locking behind him. He is aware that he does need to let staff know when he goes outside and to push the doorbell to come back inside the building. He is able to repeat this information to writer. He did not have any ill effect from being outside. On 4/18/20 at 1:12 PM, R1's Progress Note states in part: Resident crawling on floor this am with flash light and wandering into other residents rooms in his underwear frientgening (sic) other residents. Resident very confused this am. On 4/19/20 at 10:23 PM, R1's Progress Note states, in part: Nurse from 100/200 wing reports res (resident) exit seeking and not responding to redirection before supper. On 4/19/20 at 10:25 PM, R1's Progress Note, states, in part: Res staying in unit for several hours, refused to eat supper. Res quiet from 1900 (7 PM) in unit until bedtime in own room. Res responded well to 1:1 (one to one) after several hours. On 4/25/19 at 9:01 PM, R1's Progress Note, states, in part: Held-([MEDICATION NAME] XR) quetiapine [MEDICATION NAME] ER (extended release) 150mg tablet extended release 24 hour (1 tablet/150mg). Med(s) held: d/t (due to) med (medication) unavailable: request sent to pharmacy . On 4/26/20 at 7:29 PM, R1's Progress Note, states, in part: Held-([MEDICATION NAME] XR) quetiapine [MEDICATION NAME] ER 150mg tablet extended release 24 hour (1 tablet/150mg). Med(s) held: d/t med unavailable . On 4/27/20 at 7:26 PM, R1's Progress Note, states, in part: Held-([MEDICATION NAME] XR) quetiapine [MEDICATION NAME] ER 150mg tablet extended release 24 hour (1 tablet/150mg). Med(s) held: d/t med unavailable On 4/28/20 at 10:34 PM, R1's Progress Note, states, in part: Held-([MEDICATION NAME] XR) quetiapine [MEDICATION NAME] ER 150mg tablet extended release 24 hour (1 tablet/150mg). On 4/28/20 at 11:15 PM, R1's Progress Note indicates a call was placed to attending Physician regarding order for HS (bedtime) [MEDICATION NAME]. On 4/29/20 at 11:39 PM, R1's Progress Note, states, in part: Behavior: Res went out patio door and tried to climb fence to elope. Res returned to building and went out 200 door hallway. 1:1 with res for 40 minutes by this writer. Res. sat in hallway refusing to return to unit. Res stating They can't hold me here. Res eventually exchanged pleasant conversation with this writer and returned to unit. Cooperative to take HS medication. On 4/29/20 at 11:42 PM, R1's Progress Note indicates spoke with attending Physician regarding clarification of [MEDICATION NAME]. Order received for 75 mg every bedtime. On 5/1/20 at 9:17 AM, R1's Progress Notes indicates call placed to attending Physician call placed for urine analysis order as resident meets McGeers Criteria. (McGeers Criteria, is specific symptoms needed in order to meet the need for antibiotic treatment due to a potential infection.) On 5/4/20 at 4:43 PM, R1's Progress Notes, state in part: PRN med given: Quetiapine [MEDICATION NAME] 25mg tablet (3 tablets/75mg) given for agitation. Follow up after 1 hour: 05/04/2020 05:43PM (blank) There is no indication given whether the [MEDICATION NAME] was effective for R1's agitation. There is no indication of non-pharmacological interventions being tried prior to PRN [MEDICATION NAME]. On 5/5/20 at 8:55 AM, R1's Progress Note, states, in part: given for agitation. Follow up after 1 hour. 05/05/2020 09:55AM. PRN Med result: 08:55AM med effective. There is no indication of non-pharmacological interventions being tried prior to PRN [MEDICATION NAME]. On 5/5/20 at 7:24 PM, R1's Progress Note, states, in part: PRN med given: Quetiapine [MEDICATION NAME] 25mg tablet (3 tablet/75mg) exit seeking behavior. Follow up after 1 hour. 05/05/2020 08:24PM (blank) There is no indication given

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F 0758 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) whether the [MEDICATION NAME] was effective for R1's exit seeking behaviors. There is no indication of non-pharmacological interventions being tried prior to PRN [MEDICATION NAME]. On 5/21/20 at 7:39 AM, R1's Progress Notes indicates Physician Visit completed rounds with RN via telehealth. Fax received for new order for [MEDICATION NAME] 17g in non-[MEDICATION NAME] liquid once daily for constipation. There is no indication that R1's [MEDICATION NAME] or [MEDICATION NAME] orders were reviewed. On 5/27/20 at 3:40 PM, Surveyor interviewed DON B (Director of Nursing) regarding R1. DON B indicated that she was unable to find a [DIAGNOSES REDACTED]. DON B indicated that staff should be redirecting R1 before his behaviors get to the point of needing a PRN. DON B indicated that R1 did not have a care plan for wandering prior to 5/27/20. R1's Care Plan does not indicate that R1 receives PRN antipsychotic medications, what R1's targeted behaviors are or how they're exhibited. R1's Care Plan does not address what staff are to do as non-pharmacological interventions when R1 is exhibiting targeted behaviors. On 5/27/20 at 3:43 PM, Surveyor interviewed RN C (Registered Nurse) regarding R1. RN C indicated that R1's behaviors started a while back. RN C indicates R1 looks for his keys and keeps going to the window. RN C indicated if R1 can't find his keys he gets angry. RN C indicated lately R1 does not do it as often. RN C indicated PRN [MEDICATION NAME] was prescribed and now they also have [MEDICATION NAME]. On 5/27/20 at 4:06 PM, Surveyor observed R1's PRN [MEDICATION NAME] Medication card with RN C. R1's [MEDICATION NAME] card was sent on 4/29/20. RN C indicated to Surveyor 7 doses had been given based on the number of missing doses on the medication card. RN C indicated there are 23 doses left within the card. The card indicated [MEDICATION NAME] 50mg tabs, give 1.5 tablets (75mg) by mouth every evening PRN. On 5/27/20 at 4:50 PM, Surveyor interviewed RN C regarding R1's PRN [MEDICATION NAME]. RN C indicated she gave R1 PRN [MEDICATION NAME] to calm down R1's behaviors of anxiety and agitation in order for R1 to have less disruptive behaviors that could be harmful to himself or others. RN C indicated R1 wanted to hit a staff member one time, so she stayed with R1 and talked to him. RN C indicated she has not given R1 the [MEDICATION NAME] for exit seek, only for anger due to being unable to find his keys. RN C indicated it should be documented when it was given and she may not have documented the non-pharmacological interventions she used prior to giving the [MEDICATION NAME]. RN C indicated she has used non-pharmacological interventions before. On 5/27/20 at 5:14 PM, NHA A (Nursing Home Administrator) indicated to Surveyor R1 has not had a face to face completed for his PRN [MEDICATION NAME] or [MEDICATION NAME]. NHA A indicated R1's [MEDICATION NAME] has not been renewed every 14 days. On 5/27/20 at 5:28 PM, Surveyor interviewed NHA A and DON B regarding R1's [MEDICATION NAME] and behaviors. DON B indicated you would normally have a reason to give a PRN and the PRN's are reviewed with the primary care provider or a psychiatrist if they have one or an on call MD if emergent. DON B indicated per the MAR indicated [REDACTED]. DON B indicated wandering is not an appropriate reason to receive antipsychotic medications, but it's a behavior they monitor. DON B indicated that R1 gets high anxiety which causes him to have a higher level of anxiety resulting in pacing rapidly. NHA A indicated most of the time targeted behaviors are charted. NHA A indicated R1 had increased behaviors when he had a UTI (urinary tract infection) and due to a room move. DON B indicated the numbers on the MAR indicated [REDACTED]. DON B indicated R1 does not have an antipsychotic medication care plan. DON B indicated the interventions are on the CNA care plan and are to be used in general, when residents are bored. DON B indicated CNA's do not document behaviors and nurses are not documenting behaviors/behavioral interventions as they should. NHA A indicated R1 was in room (room number) at first, then was moved down to the Memory Care Unit and was being treated for [REDACTED].