STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525409	A. Building B. Wing	09/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 - Immediate jeopardy to resident health or safety 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** 37091 Based on observation, interview, and record review, the facility did not ensure each resident received adequate supervision to prevent accidents for 1 of 3 residents (R1) reviewed for wandering and elopement potential. R1 is severely cognitively impaired and has an Activated Power of Attorney for Health Care)(APOAHC). R1 has attempted to elope from the facility every day, and sometimes multiple times per day. R1 eloped from the facility on 8/12/22. R1 was missing for one and a half hours with the facility staff unable to locate R1. The facility made no changes in R1's Care Plan to prevent elopement or provide increased supervision. An alarmed door was found with the alarm disabled during the survey on 9/1/22. The facility's failure to provide adequate supervision to R1 and ensure all the alarmed doors were armed created a finding of Immediate Jeopardy which began on 8/12/22. NHA A (Nursing Home Administrator) was notified of the immediate jeopardy on 9/2/22 at 8:50 AM. The Immediate Jeopardy was removed on 9/2/22, however the deficient practice continues at a scope/severity of D (potential for harm/isolated) as the facility implements its removal plan. This is evidenced by: The facility policy entitled Elopement and Wandering Management revision dated 8/22, includes: *Always respond immediately to any activated door alarms. *When a resident is found to have new or potential elopement behaviors, this will be documented in the Nurses Notes . *Appropriate alert systems will be activated 24 hours per day/7 days per week. All door alarms and magnets will be routinely inspected as per facility preventative maintenance policy and the manufactures' directions. R1, who is [AGE] years old, was admitted to the facility on [DATE] with a diagnosis of vascular dementia with behavior disturbance. (continued on next page)

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

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1 has a Brief Interview for Mental Status (BIMS) of 4, which indicates she is severely cognitively impaired. R1 is independent with her ambulation. R1 is a resident on an alarmed memory care unit (MCU). R1's Elopement and Wandering Care Plan undated, includes: *Always respond immediately to any activated door alarms. *Approach R1 in a calm, reassuring manner. *Use redirection first, offer a diversional activity or use conversation to attempt to gain R1's cooperation. *Engage R1 in hands on meaningful activities daily. *Redirect R1 when around negative company. *Redirect when notice of over stimulation begins. *Offer R1 realistic baby doll or time in sensory room. *Redirect from exit areas and continue to encourage positive engaging activities. *Ask R1 where is attempting to do/go? Redirect R1, stay with her if she is exit seeking. *R1 was a care giver and will go to where she hears another resident's calling out. R1's Elopement and Wandering Care Plan dated 8/12/22, includes: *Always respond immediately to any activated door alarms. *Approach R1 in a calm, reassuring manner. *Use redirection first, offer a diversional activity or use conversation to attempt to gain R1's cooperation. *Engage R1 in hands on meaningful activities daily. *Redirect R1 when around negative company. *Redirect when notice of over stimulation begins. *Offer R1 realistic baby doll or time in sensory room. *Redirect from exit areas and continue to encourage positive engaging activities. *Ask R1 where is attempting to do/go? Redirect R1, stay with her if she is exit seeking. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	*R1 was a care giver and will go to where she hears other resident's calling out. The original undated Elopement and Wandering Care Plan did have the following approaches struck out: *Avoid arguing with R1. *Do not say You can't or You have to. It's important to note the struck-out sentences are the only difference in the original undated Elopement and Wandering Notification Care Plan and the 8/12/22 Elopement and Wandering Notification Care Plan. R1's Care Plan dated 12/14/21 includes Problem: Potential for Elopement and includes multiple diversional activities for staff to engage R1 in. Her Care Plan includes, It is helpful maintain a positive attitude with uplifting company and to avoid exit seeking. R1's Care Plan dated 8/12/22 includes: *Always respond immediately to any activated door alarms; do not turn off the alarm if responding alone; approach R1 in a calm, reassuring manner, approach R1 1:1 and discourage large numbers of staff around her as not to overwhelm her. Use redirection first, offer a diversional activity or use conversation to attempt to gain R1's cooperation. Ask R1 where is attempting to do/go? Redirect R1, stay with her if she is exit seeking. R1's Care Plan dated 8/18/22 includes: *Engage R1 in hands on meaningful activities daily, offer simple yet time consuming tasks for her to do. *Encourage R1 to be in a social group like setting away from the entrance of her bedroom door. Involve R1 by asking her to help with folding clothes with her peers. *Resident will go to the exit doors and open them, redirect as allows or stay with her. Surveyor reviewed R1's behavior documentation. June 2022 - R1 attempted to elope every day. On the PM shift there were 3 days when R1 attempted to elope greater than 15 times, and one day when R1 made 25 attempts to elope. July 2022 - R1 attempted to elope every day. On the PM shift, there were 15 days when R1 attempted to elope greater than 20 times, and two days R1 made 45 attempts to elope. August 2022 - R1 attempted to elope every day. On the PM shift, there were 13 days when R1 attempted to elope 20 times or greater. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Nursing/Progress notes on 8/12/22 include at approximately 4:55 PM, LPN F (Licensed Practical Nurse) was passing supper trays and noted R1 was not at the supper table in the dining room. Checked R1's room and noted resident not in room. Checked all rooms in unit and resident not found. Alerted CNA G (Certified Nurse Assistant) and AA E (Activity Assistant). AA E stated she placed R1 at dining table after coming inside from previous activity done outside on patio. LPN F went outside building and searched for R1 while searching perimeter of building. At 5:15 PM, LPN F called 911 and reported R1 missing .Several staff outside calling R1's name and walking further outside building perimeter for R1. NHA A, ANHA D (Assistant Nursing Home Administrator), and SW H (Social Worker) notified and looking for R1 . Guardian notified at 5:55 PM . R1's physician notified at 6:10 PM . At 6:25 PM, Sheriff's office called facility saying R1 was dropped off at Sheriff's office. Staff picked up R1 at 6:40 PM. R1 appeared in no distress .vital signs taken and head to toe assessment done. R1 had right lateral bruise to ankle. Mild swelling to area noted. R1 complained of pain to right ankle with palpation. Cold packs applied. Physician notified. Unsure at this time how resident left building without alarm sounding. Resident's behavior prior to incident as per usual, confused. Prior to resident's elopement, several attempts made to open outside gate were made, but failed due to AA E being present and redirected R1 away from gate. On 9/1/22 at 11:00 AM, Surveyor spoke to AA E. AA E said she had residents including R1 outside on the patio for an activity from 4:00 PM to 4:55 PM. AA E said she brought all the residents in at 4:55 PM. AA E said she is sure that R1 was not left on the patio. AA E said she propped the keypad alarm door open during the patio activity. AA E said she shut off the chime alarm and put the code in for the keypad alarm. AA E said she was sure the keypad alarm was reset but is not sure she turned the chime alarm back on. On 9/1/22 at 1:30 PM, Surveyor spoke to LPN F. LPN F said she was passing medications during the patio activity. LPN F said when she did not see R1 at the supper table when passing trays, she checked R1's room. LPN F said she asked AA E where R1 was. LPN F said AA E replied she had put R1 at the dining table, then AA E went to the kitchen for the supper trays. LPN F told CNA G to look for R1. LPN F said the alarms were working the entire shift she was there. On 9/1/22 at 1:50 PM, Surveyor spoke to the Sheriff's Department. Deputy K (Deputy) said a citizen dropped R1 off at the Sheriff's Office because R1 was standing in the road. Deputy K said the citizen said she was afraid that R1 would get hit by a car. During the investigation, door alarms were checked by the NHA, ANHA, and SW. The keypad alarms were working, but the chime alarm was in the off position. On 9/1/22 at 2:15 PM, Surveyor spoke to CNA G. CNA G said he had not noticed R1 was missing until LPN F told him to look for her. On 9/1/22, at 2:25 PM during the survey, Surveyor observed R1 sitting at the dining room table, speaking to peers, or working a puzzle. On 9/1/22 at 2:58 PM, Surveyor walked on the unit and heard the alarms sounding. R1 was at the alarmed exit door. LPN I was with R1, redirecting her in a soothing manner. LPN I walked with R1 to TV lounge and sat her in a recliner to watch TV. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	At 3:14 PM, R1 walked to exit door, walked through the alarmed door with alarms sounding. LPN I sprinted to R1 on the patio (about 60 feet) distance to help R1 back into the building. LPN I went to R1's room and got a puzzle for her to work on with another resident sitting at the table. R1 worked on the puzzle for 30 minutes until Surveyor left the unit. On 9/1/22 at 9:30 AM, Surveyor found an alarmed door showing a green light on the keypad of the alarmed door. Surveyor spoke to MD C (Maintenance Director) and asked what the green light indicated. MD C said the green light on the keypad indicated the alarm on the door was disabled. MD C said he did not know why the alarm on the door was disabled. MD C said there was a specific code used to disable an alarm on a keypad alarmed door. MD C said he was sure he did not go through that door today and the other maintenance person was working in a different building, and they were the only people with an access code to disable alarms. It's important to note that there are four residents in the facility that wander with access to the door with the disabled alarm. On 9/1/22 at 1:00 PM, Surveyor spoke to MD C about the alarmed door in the MCU. MD C said there are two alarms on the doors. The chime alarm goes off when the door is opened and stops alarming when the door is closed. The keypad alarm needs a pass-through code. When the code was applied to the keypad, someone could pass through but not prop the door open. MD C said the door would alarm in 30 seconds when the pass-through code was used. MD C said the keypad alarm resets itself in 10 seconds. Surveyor asked MD C to use the pass-through code and MD C propped the door open for two minutes. The keypad alarm did not sound. MD C said he could not understand why the alarm was not sounding when he propped the door open. Surveyor timed the keypad alarm after the door was closed. The keypad alarm did reset itself in 10 seconds. Surveyor asked MD C how often he checked the alarms for being armed and working. MD C said he checked the alarms every day. Surveyor asked how he checked the alarms.MD C said prior to the elopement, he checked the alarms by observing the light on the keypad. MD C said if the light was red, it meant the door was armed and the alarm was working. MD C said now, after R1 eloped, he checked the MCU door alarm by opening it and making sure it alarmed when opened. MD C said he placed a motion sensor on the outside gate that alarms in the building if someone goes through the outside gate. On 9/1/22 at 5:05 PM, Surveyor spoke to ANHA D and SW H. ANHA D and SW H worked on the investigation of R1's elopement. ANHA D and SW H are also the facilitators of the Person At Risk (PAR) committee for residents with wandering and elopement behaviors. Surveyor asked ANHA D and SW H if they tracked and looked at patterns of behaviors. ANHA D and SW H said no. Surveyor asked what changes have been made to R1's Care Plan to prevent any further elopements. ANHA D and SW H said they updated R1's care plan. Surveyor asked ANHA D and SW H to show Surveyor what changes had been made to R1's care plan. ANHA D and SW H reviewed and compared the original care plan and new care plan for R1. They pointed out the struck-out interventions of do not argue with R1 and do not say you can't, or you have to. Surveyor asked if there were any further changes to prevent R1 from eloping again. ANHA D and SW H said they started an audit of nursing staff checking the alarms on the door in MCU to make sure they are working and checking that R1 has her name bracelet on, and that MD C placed a motion sensor on the outside gate. ANHA D and SW H said those were the changes made to prevent R1 from eloping again. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 9/1/22 at 5:30 PM, Surveyor spoke to NHA A. NHA A said that ANHA D and SW H had worked on the investigation and follow up changes to R1's care plan, and that MD C put a sensor motion alarm on the outside gate. All staff were educated on the door alarms and the elopement and missing person policies. Because R1 was found in the roadway, she was at risk for being hit by a vehicle. According to the article, The Problem of Pedestrian Injuries and Fatalities, Unsafe pedestrian behavior is a major factor in pedestrian injuries and fatalities. In a recent study of 7,000 pedestrian-vehicle crashes in Florida, researchers discovered that pedestrians were at fault in 80 percent of these incidents. Similarly, in a U.K. study, pedestrian behavior accounted for 90 percent of crashes where a vehicle struck a pedestrian. This article notes that, Given a crash, the faster the vehicle the more severe the injury to the pedestrian. For example, a pedestrian hit at 40 miles per hour has an 85 percent chance of getting killed, whereas the likelihood goes down to 45 percent at 30 miles per hour and 5 percent at 20 miles per hour. https://popcenter.asu.edu/content/pedestrian-injuries-fatalities-0 R1 could also have suffered injuries from a fall on the uneven terrain outside. The article, For Elderly, Even Short Falls can be Deadly, notes that even short falls can be harmful, especially to those [AGE] years or older. According to this article, While simple falls, such as slipping while walking off a curb, may seem relatively harmless, they can actually lead to severe injury and death in elderly individuals, according to a new study published in The Journal of Trauma: Injury, Infection, and Critical Care .In contrast to falls from greater heights, ground-level falls - essentially falls from a standing position, with feet touching the ground prior to the fall - have traditionally been considered minor injuries. But, the new study found elderly adults - [AGE] years or older - who experience ground-level falls are much more likely to be severely injured and less likely to survive their injuries compared to adults younger than [AGE] years. Elderly patients are three times as likely to die following a ground-level fall compared to their under-70 counterparts. http://www.urmc.rochester.edu/news/story/index.cfm?id=3020 The facility's failure to ensure R1 had adequate supervision and that door alarms were armed created a reasonable likelihood of serious harm which led to a finding of Immediate Jeopardy. The Immediate Jeopardy was removed on 9/2/22 when the facility began implementing the following: ~All staff were immediately educated on the policies Elopement - Missing Resident Response and Elopement and Wandering Management. They were also reeducated on the alarm system for the door which resident exited from and ensuring a resident sweep/count is completed when residents go outside of the facility and come back in. ~All alarms were recoded to ensure that staff do not know the code to disengage alarms. ~All residents who are at risk for wandering/elopement were audited, reassessed as required, and care plans were updated for appropriateness. ~Affected resident's care plan was updated to include offer increased structured activities to resident that are specific to her, daily itinerary to help deter from exit seeking, i.e., ice cream social, movie in sensory room, puzzle, sorting activities, etc. ~Increased staffing of MCU to include daily manager rounds as well as weekend manager rounds. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	~Resident to be in line of sight of staff during awake hours. ~Daily MCU door check audit to include ensuring alarms are engaged to alarm properly by maintenance director or designee to be completed and brought to ID Team each day. ~Random spot checks with staff on elopement attempts to help monitor timeliness of response to alarms. This will be done daily x 2 weeks, and then 3x weekly for 4 weeks by manager rounds. ~Increased rounding daily on memory care unit x4 weeks by all management staff to ensure residents are engaged and not exit-seeking and there is sufficient staff. ~Wandering and elopement assessments and care plans will be reevaluated weekly ongoing through facility care plan meetings and facility person-at-risk meetings over the next 12 weeks and changes made as appropriate.